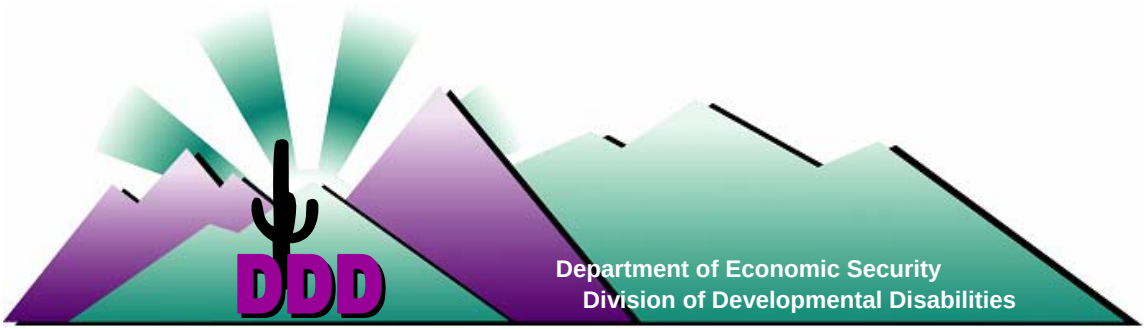
ARIZONA DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES



THIRD PARTY LIABILITY BILLING GUIDE FOR THERAPY PROVIDERS

April 2006

http://www.azdes.gov/ddd/

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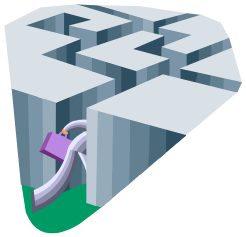
The information in this guide is intended to help the provider with billing insurance companies. Content in this guide is subject to change at any time.



Introduction

This Billing Guide provides a resource to our contracted therapists who are providing services to our clients. The Division of Developmental Disabilities (DDD) requires Third Party Liability (TPL) billing for all individuals served by contracted service providers. Third Party Liability is defined as any entity that is, or may be, liable to pay all or part of the medical cost of care before the Division of Developmental Disabilities pays towards the claim.

The Division reimburses for covered services only after all available third-party benefits are exhausted. Payments made under the DDD program must be reduced to the extent that they are offset by a third-party resource. As part of their condition of eligibility, per Arizona Administrative code R6-6-1301, during the application process with the Division, the applicant must provide all third party liability information.

Providers are expected to take reasonable measures to ascertain any third-party resource available to the client and to file a claim with that third party. In such instances, the Division will not reimburse for the cost of services, which are or would be covered by a third-party payer if billed to that third-party payer and payment is more than the providers contracted rate with the Division. If the provider receives a third-party payment after having received a payment from the Division for the same items and services, the Division must be reimbursed the payment made to the provider.

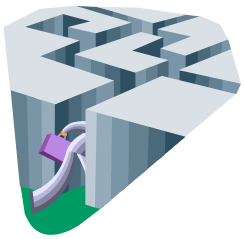
It is not the intent of the Division to delay payment to a provider for the covered services because of an pending third-party liability. If a payment (or denial) is not forthcoming from the insurance company within sixty to ninety days and the provider has made multiple attempts with the insurance company to try to obtain a payment or denial, the provider should notify the Benefits Coordinator and request a waiver. More about the waiver process in Chapter 5**.**

Resources for data gathering in regard to the types of insurance/third-party funding available are pointed out in **Chapter 1.** Providers interested in accessing insurance will want to have an understanding of the variety of health-coverage plans available. The description of private insurance, Health Maintenance Organizations (HMOs), self-funded plans, and other government plans in this chapter will be helpful not only for funding purposes, but also as the provider/service coordinator consults with parents and/or guardians. **Chapter 2** discusses documentation requirements of insurance carriers and HMOs for the initiation and continuation of treatment. Included is a sample Insurance Coverage Verification Form.

Chapter 3 provides information regarding procedure and International Classification of Diseases (ICD-9) codes and the tools providers will need to use to establish fees for services.

A line-by-line approach for completion of the basic Centers for Medicare and Medicaid (CMS) 1500 claim form, which is used for private insurance, HMOs, and AHCCCS, is found in **Chapter 4.**

Chapter 5 provides the reimbursement process of the claim, from gathering the data for services rendered to recording the payment. The waiver process is explained on page 36.



HIPAA

(Health Insurance Portability & Accountability Act of 1996)

HIPAA is a Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care.

Any healthcare provider that *electronically* stores, processes or transmits medical records, medical claims, remittances, or certifications must comply with HIPAA regulations. HIPAA does not require a practice to purchase a computer-based system as it applies only to electronic medical transactions.

"Covered entities" are regulated: HIPAA directly regulates the following three types of "covered entities":

1. Health plans (insurers, Health Maintenance Organizations, Medicaid, etc.);
2. Health care clearinghouses (entities that help health care providers and health plans standardize their health information); and
3. Health care providers who transmit health information in electronic form in connection with a HIPAA transaction. It is important to recognize that there is a two-part determination for deciding whether an entity is a covered health care provider:

   Part one -- A "Health care provider" is defined as any person who, in the normal course of business, furnishes, bills, or is paid for "health care." The term "health care" is defined quite broadly to include preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical and mental condition, or functional status of an individual or that affects the structure or function of the human body.

   Part two -- HIPAA transactions are exchanges of information between two parties to carry out financial or administrative activities related to health care, including transactions such as filing a health insurance claim with an insurer and determining eligibility for health insurance.

HIPAA-compliant refers to the doctors, hospitals and insurance companies themselves that are in compliance with HIPAA regulations. HIPAA regulations give health-care organizations the decision to decide how they will implement HIPAA compliance, and are technology and software-neutral.

Penalties for HIPAA non-compliance: Fines up to $25,000 for multiple violations, $250,000 or imprisonment up to 10 years for knowing abuse or misuse of individually-identifiable health information.

For more information about HIPAA, go to: http://www.hhs.gov/ocr/privacysummary.pdf

NPI

(National Provider Identifier)

The Health Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for health care providers. The NPI Final Rule issued January 23, 2004 adopted the NPI as this standard.

What is a National Provider Identifier?

- The NPI is a 10-digit, intelligence free numeric identifier (10 digit number). Intelligence free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization.
- The NPI will replace health care provider identifiers in use today in HIPAA standard transactions. Those numbers include Medicare legacy ID's (UPIN, OSCAR, PIN, etc.).
- The provider's NPI will not change and will remain with the provider regardless of job or location changes.

Having an NPI does not:

- Ensure a provider is licensed or credentialed;
- Guarantee payment by a health plan;
- Enroll a provider in a health plan;
- Turn a provider into a covered provider; and
- Require a provider to conduct HIPAA transactions.

Health care providers can apply now for their NPI on the National Plan and Provider Enumeration System (NPPES) web site *https://nppes.cms.hhs.gov/NPPES/Welcome.do*.

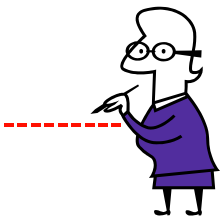
Why do we need the National Provider Identifier?

- Simpler electronic transmission of HIPAA standard transactions;
- Standard unique health identifiers for health care providers, health plans, and employers; and
- More efficient coordination of benefits transactions.

Who can apply for the NPI?

- All health care providers (e.g., physicians, suppliers, hospitals, and others) are eligible for NPIs. Health care providers are individuals or organizations that render health care.

- All health care providers who are HIPAA-covered entities, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, Health Maintenance Organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI to identify themselves in HIPAA standard transactions.



NPI

(National Provider Identifier), continued

Is a sole proprietor/sole proprietorship an individual or an organization?

A sole proprietor/sole proprietorship is an individual and is eligible for a single NPI. The sole proprietor must apply for the NPI using his or her own SSN, not an EIN even if he/she has an EIN. Because a sole proprietor/sole proprietorship is an individual, he/she cannot be a subpart and cannot designate subparts.

Who cannot receive an NPI?

Any entity that does not meet the definition of a "health care provider" at 45 CFR 160.103, which would include billing services, value-added networks, re-pricers, health care clearinghouses, non-emergency transportation services, and others.

What is the deadline for applying and when will the NPI be effective?

All Entities:

- Health Insurance Portability & Accountability Act of 1996 (HIPAA) covered entities such as health care providers who conduct HIPAA standard transactions, health care clearinghouses, and all but small health plans, must use **only** the NPI to identify HIPAA covered health care providers in standard transactions by **May 23, 2007**. Small health plans (less than 5 million dollars in annual revenues) must use **only** the NPI by **May 23, 2008**.

Medicare Providers:

- Medicare Fee-For-Service (FFS) providers can begin to use the NPI January 3, 2006. Medicare systems will accept claims with an NPI, but an existing Medicare legacy identifier **must also be on the claim**.
- Starting October 2, 2006, Medicare FFS providers may submit an existing Medicare legacy identifier and/or an NPI on claims.
- If you are not a Medicare FFS provider or supplier, you need to be aware of the NPI readiness schedule for each of the health plans with which you do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in HIPAA standard transactions.

A Centers for Medicare and Medicaid Services (CMS) web page dedicated to providing all the latest NPI news for health care providers is available at http://www.cms.hhs.gov/NationalProvIdentStand/ on the web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation.

Chapter 1

HEALTH INSURANCE CARRIERS AND MANAGED CARE ORGANIZATIONS

There are more than two thousand health insurance carriers in the United States, with that number including Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's) and Exclusive Provider Organizations (EPO's). Many of these carriers have several types of plans that are tailored to meet the needs of their insured's. The insurance carrier may also be called an insurer, underwriter or administrative agent. The insurance carrier provides coverage as outlined in the contract with the entity purchasing the insurance (employer or individual).

Most third-party payers issue an identification card, which provides the plan information necessary for claims processing. Plan specifics can vary significantly by both carrier and employer specifications. Therefore, even clients insured by the same carrier may have different plan benefits. The provider's billing personnel should call the insurance carrier, identify themselves as a provider and request information about any policy limitations regarding the services being rendered. A sample benefit inquiry form is on page 25. Most carriers will provide the necessary information. Obtaining coverage limitations prior to initiation of services saves time and administrative costs. The information provided by the carrier is not a guarantee of reimbursement to the provider. More detailed information about this process is explained in Chapter 2.

With the exception of HMO or PPO plans, most standard indemnity carriers do not require prior authorization for evaluation or therapeutic services, but do require standard documentation procedures. It is not unusual for a carrier to request copies of documentation. Payment for services is made to the beneficiary or assigned provider, based on an indemnity table or schedule of benefits for the medical services. Assignment of benefits by the insured does not always guarantee direct payment to the provider. Some policies limit direct payment to the insured, such as some Blue Cross Blue Shield and United Healthcare policies, while others disallow assignment of benefits. In these cases, the provider is responsible for tracking funding and seeking payment from the insured.

The following are standard documentation procedures that are accepted by most insurance carriers when services are provided by licensed, certified practitioners:

A. Physician authorization / script with the following listed:
    1. Type of therapy or nursing
    2. Diagnosis
    3. Duration of treatment

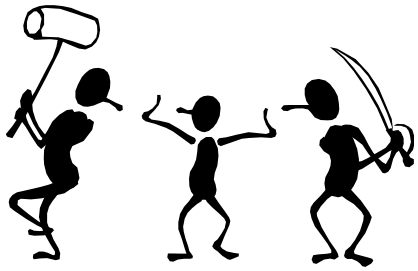
B. Documentation of the evaluation and results (report)

C. Progress documentation

See Chapter 2 for more complete information about documentation requirements.

The majority of insurance plan changes occur in the month of January. Therefore, it is essential for the provider to verify current plan information given during a client's initial intake with the Division, quarterly through the calendar year and again in January if the client is continuing to receive nursing or therapy. Filing with a plan that no longer insures the client is time-consuming and costly.

Types of Third-Party Payers



Third-party payers can be categorized as follows: Private/Commercial, Blue Cross/Blue Shield (BCBS), Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), self-insured plans, Tricare, Medicare, and AHCCCS. The following pages will outline each type of plan.

1. Private Insurance (Commercial)

Up until about 30 years ago, most people had traditional indemnity coverage. These days, it's often known as "fee-for-service" or indemnity. Indemnity plans are somewhat like auto insurance: a certain amount of the medical expense is paid up front in the form of a deductible and afterward the insurance company pays the rest or the majority of the bill.

Fee-for-service plans usually involve more out-of-pocket expenses. Often there is a deductible, usually of about $200-$2,500 before the insurance company starts paying. Once the deductible is paid, the insurer will pay about 80 percent, depending upon the percentage. Most plans offer an 80/20 option although a 70/30 or 60/40 split is not unheard of.

Under fee-for-service plans, insurers will usually only pay for “reasonable and customary" medical expenses, taking into account what other practitioners in the area charge for similar services. Fee-for-service plans often include a ceiling for out-of-pocket expenses, after which the insurance company will pay 100 percent of any costs. The ceiling is usually pretty high.

Medical insurance can be purchased through group or individual policies. Under group insurance, coverage is provided for a number of people through the use of a single policy. The contractual relationship is between the insurer and the named policyholder (usually the employer). Under an individual policy, the insured individual is the policyholder. Group insurance coverage generally costs less and provides more comprehensive coverage than individual coverage because the "risk" absorbed by the insurer is less concentrated, and its administrative costs can be spread over a greater number of persons.

In conclusion, fee-for-service coverage offers flexibility in exchange for higher out-of-pocket expenses, more paperwork and higher premiums.

<u>Important note</u>: The parent can also call their child’s physician’s office and have the referral clerk initiate the authorization process. Asking parents to be involved in the prior authorization process may help to expedite the process. If that process were started at intake, in some instances, the authorization or denial would be in place before therapy takes place.

2. Blue Cross Blue Shield (BCBS)

Nationwide, the most recognizable service type organization involves the Blue Cross/Blue Shield (BCBS) concept. Although originally separate entities, Blue Cross and Blue Shield merged to provide comprehensive coverage for hospital and non-hospital services. BCBS functions much as a commercial carrier does, except in its language definitions for contracts and subscribers: BCBS routinely requires providers to meet BCBS standards and enroll in order to become participating providers. The provider requirements for reimbursement by BCBS vary by plan and state.

Historically, there was a clear distinction between the BCBS and "commercial" carriers. The Blue Cross/ Blue Shield concept was based on the promise of provision of hospital/medical services as required by the patient. The insured person was described as a subscriber to Blue Cross/Blue Shield plans; the plans established contractual relationships with hospitals and doctors. In the early 1980's, the BCBS concept began to change. The district Blue Cross and Blue Shield plans combined to form Blue Cross/ Blue Shield of Arizona. Blue Cross/Blue Shield of Arizona now operates as a commercial carrier.

Arizona Well Point Blue Cross Networks

Blue Cross Blue Shield of Arizona (BCBSAZ) offers coverage through the BluePreferred, BlueSelect, BlueClassic, BluePreferred Basic, and Participating networks described below:

BluePreferred, a preferred provider organization (PPO) plan that does not require members to meet a deductible before making copays for most PPO doctors.

BluePreferred Saver, a high-deductible preferred provider organization (PPO) plan that renders all services (except prenatal care) applicable under the member's deductible. This plan meets federal requirements for use with a health savings account (HSA), and members who meet eligibility criteria may elect it.

BlueClassic, an indemnity plan that gives members the freedom to choose their preferred hospital or physician. Members may also choose from among six deductibles, ranging from $250 to $5000.

BlueClassic Saver, a high-deductible indemnity plan with lower out-of-pocket costs for members who use Participating providers. This plan meets federal requirements for members who qualify to use it with a health savings account (HSA).

BlueSelect, a health maintenance organization (HMO) plan that requires member copays for covered services.

For more information about Blue Cross Blue Shield plans, go to www.bcbsaz.com

3. Managed Care

There are three basic types of managed care plans: (1) Health Maintenance Organizations (HMOs), (2) Preferred Provider Organizations (PPOs), and (3) Point of Service (POS) plans. Although there are important differences between the different types of managed care plans, there are similarities as well. All managed care plans involve an arrangement between the insurer and a selected network of health care providers (doctors, hospitals, etc.). All offer policyholders significant financial incentives to use the providers in that network. There are usually specific standards for selecting providers and formal steps to ensure that quality care is delivered.

Health Maintenance Organizations (HMOs)

In an HMO, you pay a fixed monthly fee, called a premium. In return, the health insurance company and its health care network provide a variety of medical benefits. The range of health care services covered by an HMO varies, so it is important to compare available plans. Some health care services, such as outpatient mental health care or therapies, are often only covered on a limited basis.

Health maintenance organizations consist of a network of physicians. From this list, you choose a primary care physician, who is then responsible for your health care as well as for making referrals to specialists and approving further medical treatment. Usually, your choice of doctors and hospitals is limited to those on the list - since they have agreements with the HMO to provide your health care. However, exceptions may be made in emergencies or when medically necessary.

Generally, the health care services offered will require you to make a co-payment. A standard payment is five to ten dollars per doctor visit and five dollars for prescriptions. Some health insurance plans and some services charge nothing. The drawback of any HMO policy is that no care received outside of the health care network is covered.

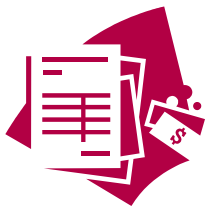
Advantages and disadvantages of HMO health insurance

Many people like HMO health insurance because they do not require claim forms for office visits or hospital stays. Instead, HMO members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with an indemnity insurance plan.

Because the HMO health insurance company charges a fixed fee for your health care, it is in their interest to make sure you get basic health care for your medical problems before they become serious. Although there may be a small co-payment for each office visit, your total health care costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

Unfortunately, there are drawbacks to these health insurance plans too. It is difficult to get specialized care under an HMO plan since you must first obtain a network referral. Any health care cost from other providers, except in emergencies, is not covered. The most problematic, however, is that situations covered as emergency care are strictly limited.

Since an HMO exercises more control over your health care than other managed care plans, the cost is also more controlled. On top of the monthly health insurance premium, there are very few other fees when using network providers. For health care services covered under the plan, HMO plans require you to make minimal co-payments for services rendered. Non-network care, however, is rarely ever covered. Instead, you are responsible for paying the entire medical bill.



Preferred Provider Organizations (PPOs)

On a health insurance "scale", PPO insurance lies between Health Maintenance Organizations (HMOs) and pure fee-for-service plans. Your health care is managed (and so restricted), but you are granted a degree of choice in providers. A PPO health insurance plan operates like an HMO in that you pay a fixed monthly premium, and, in return, the health insurance company and its health care network provide basic medical benefits to you, normally with a co-pay accessed for each doctor or therapy visit.

However, a PPO does differ from the original HMO blueprint, primarily in that under a PPO insurance plan, a primary care physician or "gatekeeper" physician is not required. As a result, seeing a specialist does not require a referral. If you need or want health care from *outside* the network, you should expect to pay a higher co-payment than if the provider were from within the PPO network.

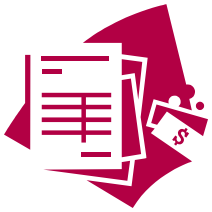
In essence, each time you need medical attention, you can decide between a higher costing indemnity plan with total freedom of choice over care or a lower costing HMO plan that restricts your care to within a network.

Advantages and disadvantages of PPO insurance:

- Health care costs are low when using the PP0 networks.
- You can consult any specialist, including ones outside the plan.
- Seeing a primary care physician is not a prerequisite.
- Paperwork is your responsibility if the care is non-network.
- Out-of-pocket costs per year are limited.
- Cost of treatment outside of network is more expensive.
- Co-payments are larger than with other managed care plans.
- You may need to satisfy a deductible.

PPO insurance is generally the most expensive type of managed care plan. Even with a premium comparable to an HMO, the *other* fees associated with PPO insurance can increase its cost significantly. On top of the premium, you can expect to pay coinsurance (lower charges if using network providers and higher charges if using non-network providers). For preventative services, co-insurance is usually waived and, instead, but may be replaced with a (low) co-payment. Co-pays are not allowed to be assessed to the families you serve, per your contract with the Division, as the co-pay amount is built into your rate schedule. Please see the Special Terms and Conditions of your contract for more information.

With non-network care, you must satisfy a deductible before the health insurance company begins contributing. After the deductible is met, you pay a higher percentage of the cost and may also be require to pay the difference between what the health care provider charges and what the plan deems to be "reasonable and customary" for the service.



Point of service (POS) plans

The POS is based on the basic managed care foundation: lower medical costs in exchange for more limited choice. But POS health insurance does differ from other managed care plans. When you enroll in a POS plan, you are required to choose a primary care physician to monitor your health care. This primary care physician must be chosen from within the health care network, and becomes your "point of service".

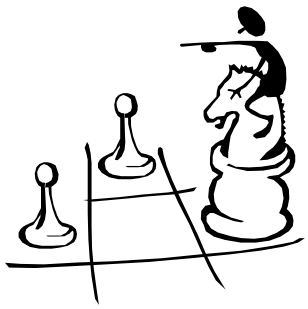
The primary POS physician may then make referrals *outside* the network, but then only some compensation will be offered by your health insurance company. For medical visits within the health care network, paperwork is completed for you. If you choose to go outside the network, it is your responsibility to fill out the forms, send bills in for payment, and keep an accurate account of health care receipts.

Advantages and disadvantages of POS health insurance

- You have maximum freedom (for managed care).
- You are not limited to only Health Maintenance Organization (HMO) network providers.
- For network care, co-payments are low & there is no deductible.
- Annual out-of-pocket costs are limited.
- Co-payments for non-network care are high.
- There is a deductible for non-network care.
- Getting referrals for specialists may be difficult.

The breakdown of cost under a POS plan is similar to that of other managed care plans. It may be slightly less costly than a Preferred Provider Organization (PPO) because the health insurance company will still regulate most of your health care. Your actual costs will consist of the monthly premium and a co-payment for health care services covered under the plan and within the POS network.

You'll also carry a deductible on any non-network care, and after the deductible is met, you'll still pay a higher percentage of the cost and maybe the difference between what the health care provider charges and what the plan deems to be "reasonable and customary" for the service.



4. Self-insured Plans

Self-insured plans, Exclusive Provider Organization's (EPO's) represent a form of health insurance under which the healthcare benefits are designed and dictated by the employer. Due to the rapidly increasing high cost of healthcare, this type of health plan is growing because major corporations have found it less costly to provide their own healthcare plans and dictate the benefits.

Some employers and employee groups have been able to achieve cost savings by assuming all or a portion of the risk of health benefits offered to their employees. Some organizations have also demonstrated the ability to realize savings by processing health claims and paying medical care providers directly. These situations of assumed risk and claims administration are usually referred to as "self-insurance" or "self-funded" or "self-administered."

An employer that performs these functions from within its own resources is not "insured" since there is no transfer of risk. The employer retains the potential for loss for all covered medical expenses incurred by the employees and dependents. An employer can transfer some of this risk by purchasing "stop-loss" coverage from a commercial carrier. For a premium, the commercial carrier will assume the covered medical expenses of an individual who has reached some stated threshold, perhaps $50,000 in medical expenses in any one policy year. The employer may also pay for commercial coverage, which reimburses the employer for medical expenses paid out in total, perhaps $1,000,000 for all covered employees.

Self-insured health plans are not subject to the state laws that regulate the insurance industry. The Employee Retirement Income Security Act (ERISA) prohibits individual states from considering self-insured/funded plans as insurance companies for regulation purposes. For regulatory questions regarding self-funded plans contact:

Pension & Welfare Benefits Administration

Room N-6544

200 Constitution Avenue NW

Washington, D.C. 20210

For more information online about the U.S. Department of Labor, go to:

http://www.dol.gov/dol/topic/health-plans/erisa.htm

5. Tricare

TRICARE is a federal program created for the benefit of dependents of personnel serving in the uniformed services. The federal government maintains TRICARE, not as an insurance program, but rather as a service-connected benefit. Tricare coverage is secondary to commercial health plans, but primary over AHCCCS. TRICARE is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. To use TRICARE, clients must be listed in the Defense Enrollment Eligibility Reporting System (DEERS) as being eligible for military health care benefits. The main TRICARE programs are Prime, Standard and TRICARE for Life. Listed below are brief summaries of each as well as the Extended Care Health Option (ECHO) program.

TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime beneficiaries receive most of their care from a military treatment facility (MTF), and are guaranteed access to care. A primary care manager (PCM) provides and coordinates the client's care, maintains their patient health records, refers them to specialists, and files claims for them. Specialty care must be arranged and approved by the PCM to be covered under TRICARE Prime.

TRICARE Standard is the basic TRICARE health care program for people not enrolled in TRICARE Prime. (Active duty service members are enrolled in Prime, and many other beneficiaries choose to enroll.) Standard is a fee-for-service plan that gives beneficiaries the option to see any TRICARE-certified/ authorized provider (doctor, nurse-practitioner, lab, clinic, etc.). Standard offers the greatest flexibility in choosing a provider, but it will also involve greater out-of-pocket expenses for the client. Standard requires that a yearly deductible is satisfied before TRICARE payments begin, and the client is required to pay co-payments or cost shares for outpatient care, medications, and inpatient care.

TRICARE for Life (TFL) is an enhanced health care benefit for Medicare-eligible uniformed service retirees (including retired guard members and reservists), their eligible family members and survivors, and Medicare-eligible Congressional Medal of Honor recipients. There are no enrollment fees or premiums for TFL, but retirees must be enrolled in Medicare Part B and pay the Part B monthly premium. TFL will pay the out-of-pocket expenses not covered by Medicare and other private health insurance.

Extended Care Health Option The Program for Persons with Disabilities (PFPWD) was phased out in September 2005. In addition to coverage received via the primary TRICARE plan, TRICARE ECHO benefits may include: Medical and rehabilitative services, training to use assistive technology devices, special education, institutional care when a residential environment is required, transportation under certain circumstances, assistive services, such as those from a qualified interpreter or translator, for beneficiaries whose visual or hearing impairment qualifies them for ECHO benefits, durable equipment, including adaptation and maintenance, in-home medical services through TRICARE ECHO Extended Home Health Care (EHHC), in-home respite care services (Note: Only one of the following respite care benefits may be used in a calendar month.), ECHO Respite care-16 hours per month when receiving other authorized ECHO benefits, EHHC Respite care-up to 40 hours per week (eight hours per day, five days per week) if homebound.

Services covered under the basic TRICARE benefit cannot be authorized under the TRICARE ECHO program-those services must be authorized under the TRICARE program option the beneficiary is using (TRICARE Prime, TRICARE Prime Remote, TRICARE Standard, TRICARE Extra). If a beneficiary's family member has a condition that may qualify for services under TRICARE ECHO, they should contact their regional contractor for assistance.

For more information about Tricare, go to: www.tricare.osd.mil

6. Medicare

Medicare is a health insurance program for people age 65 and older, people under 65 with certain disabilities and people of all ages with end-stage renal disease. Medicare is comprised of “Parts” – Part A, hospital insurance, Part B, medical (outpatient) insurance and Part D, the prescription drug benefit.

Only Medicare-certified providers are allowed to bill Medicare. If you are not a Medicare-certified provider, only bill the Division. Contact the Benefits Coordinator for more information.

Medicare will pay for most health care expenses, but not all of them. In particular, Medicare does not cover most nursing home care or long-term care services in the home. Medicare usually operates on a fee-for-service basis. Health Maintenance Organizations (HMOs) and similar forms of prepaid health care plans such as Preferred Provider Organizations (PPOs) are also available to Medicare enrollees. There are four main Medicare Advantage Plans: Medicare HMO Plans, PPO Plans, Special Needs Plans and Private Fee-For-Service Plans.

The best source of information on the Medicare program is the *Medicare Handbook*. This booklet explains how the Medicare program works and what the benefits are. To order a free copy, write to: Health Care Financing Administration, Publications, N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850. You can also contact your local Social Security office for information.

Some people who are covered by Medicare buy additional private insurance, called "Medigap" policies, to pay the medical bills that Medicare doesn't cover. Those policies are secondary to Medicare. Some Medigap policies cover Medicare's deductibles; most pay the coinsurance amount. Some also pay for health services not covered by Medicare. Some DDD clients may qualify for a Qualified Medicare Beneficiary (QMB) plan as a secondary. See the chart on page 18 for more about that and other plans.

For more information about Medicare, go to: www.cms.hhs.gov/home/

7. Arizona Health Care Cost Containment System (AHCCCS)

On October 1, 2005, the AHCCCS acute care program began its 24th year of operation and has matured into a national model for the delivery of managed care. Likewise, the Arizona Long Term Care System (ALTCS), in its fourteenth year of operation, has been recognized as a model for delivering long term care services in a managed care environment. In 1981, because of their concern about the growing cost of indigent health care and the burden to the counties, the Governor and the Arizona Legislature began to explore various options which would relieve the counties' fiscal problems by bringing Medicaid dollars into the State for the first time. On October 1, 1982, Arizona became the last state in the nation to implement a Medicaid program. Prior to that time, health care for the indigent was provided and fully funded by the Arizona counties. AHCCCS health care coverage is comprised of:

- Acute care services including outpatient health services, hospital, pharmacy and durable medical equipment, laboratory and x-ray, specialty care, home health and family planning.
- Long term care services including home and community based services (HCBS), alternative residential settings, nursing facilities, intermediate care facilities for the mentally retarded, hospice, acute care services, case management, and behavioral health.
- Payment of Medicare premiums, coinsurance and deductibles for individuals who are Qualified Medicare Beneficiary (QMB) Only (no services are provided by AHCCCS), and
- Emergency services only for individuals who qualify for the Federal Emergency Services (FESP) and State Emergency Services (SESP) programs.

Please keep in mind that you do not have to bill the client's AHCCCS plan for any services — the Division is the AHCCCS-contracted plan for therapies and nursing for habilitative purposes.

For more information about AHCCCS, go to: www.azahcccs.gov

Income Limits for AHCCCS Eligibility – January 1, 2006

Monthly Income Limit									
Household Size → / ↓ Coverage for: % FPL ↓	1	2	3	4	5	6	7	8	9
All Arizona Residents Most Programs* 100%	$798	$1,070	$1,341	$1,613	$1,885	$2,156	$2,428	$2,700	$2,971
Higher Limits with Full Coverage									
Pregnant Women S.O.B.R.A. 133%		$1,422	$1,784	$2,145	$2,506	$2,868	$3,229	$3,590	$3,952
Children Under 1 year S.O.B.R.A. 140%	$1,117	$1,497	$1,878						
Children Under 1 - 5 years S.O.B.R.A. 133%	$1,061	$1,422	$1,784						
Children Ages 0-18 KidsCare (Premium) 200%	$1,595	$2,139	$2,682	$3,225	$3,769	$4,312	$4,855	$5,399	$5,942
Parents Living with their Eligible Children Ages 0-18 HIFA Parents (Premium) 200%	$1,595	$2,139	$2,682	$3,225	$3,769	$4,312	$4,855	$5,399	$5,942
Special Limits that Permit Deduction of Recent Allowable Medical Expenses									
All Arizona Residents M.E.D. Program 40%	$319	$428	$537	$645	$754	$863	$971	$5,399	$5,942
Help with Medicare Deductibles & Coinsurance									
Medicare Beneficiaries Medicare Cost Sharing SLMB 120%	$957	$1,283							
Medicare Beneficiaries Medicare Cost Sharing QI 135%	$1,077	$1,444							
Nursing Home Care and Equivalent Home and Community Services									
Arizona Long Term Care System *300% of the Federal Benefit Rate (FBR)*	$1,809								

- The Medicare Cost Sharing Programs income limits are for a single person (household size 1) or a married couple (household size 2). These programs provide an income deduction for dependent children.
- For S.O.B.R.A., adult's income is redistributed among the adult and his or her spouse and children. S.O.B.R.A. programs do not count siblings when determining children's eligibility or children's when determining the parents' eligibility. Therefore a S.O.B.R.A. child's household never has more than three members. For S.O.B.R.A. pregnant women, each expected baby is added to the household size.
- The M.E.D. program reviews three months of income at the monthly amount above. Members are responsible to pay medical expenses deducted to become eligible

"Most programs" Include S.O.B.R.A. Children age 6 and over, SSI-MAO, AHCCCS fro Families and Children, AHCCCS Care and Qualified Medicare Beneficiary (QMB).
All programs allow certain deductions and/or disregards. These vary by program.
All programs also have other requirements that vary by program.
All programs require United States Citizenship or Eligible Immigrant status and a Social Security Number to be eligible for full coverage.
Emergency coverage may be available to immigrants who do not meet the requirements.
Family members who do not want AHCCCS Health Insurance are not required to provide information about citizenship, immigration status or Social Security Number.

Income limits subject to change

January 1, 2006

Reproduction from AHCCCS website

3 Providers who have payment or contract disputes with insurers should submit written grievances directly to the insurer. Grievances should not be submitted to the Insurance Department, which is not authorized to resolve them.

4 Insurers must file grievance reports twice a year with the Department. The Department has established reporting requirements that include the:

- Number of grievances filed and the type of resolution.
- Average number of days to resolution.
- Type of grievance.
- Average amount in dispute per payment grievance.

ROLE OF THE ARIZONA DEPARTMENT OF INSURANCE

1. The Department is not able to adjudicate individual claims or resolve disputes between insurers and providers. The new law does not give the Department either the authority or the resources to take those steps.

2. If providers contact the Department for help with particular claims or grievances, the Department will refer health care providers to each insurer's designated grievance contact person.

3. The Department will make the insurer grievance reports available to the public and will use the reports, as well as other information, to investigate possible violations of applicable laws. The Department will enforce the law as appropriate.

4. The Department has established a Provider Information Line at (602) 912-8468 to provide information about the timely pay and grievance law. TheDepartment has other information available on its web site at www.id.state.az.us

HELPFUL INFORMATION

Department Web Site: www.id.state.az.us

- **For a copy of a comprehensive bulletin on the law, see Circular Letter 2000-15.**
- **For a copy of this pamphlet, look under Insurers.**

Provider Information Line: (602) 912-8468

Provider Information E-mail Address:
providerinfo@id.state.az.us

Text of Timely Pay/Grievance Law:
www.azleg.state.az.us/ARS/20/title20.htm
A.R.S. § 20-3101, et seq.

Persons with disabilities may request that materials be presented in an alternative format by contacting the ADA Coordinator at (602) 912-8402. Requests should be made as early as possible to allow time to procure the materials in an alternative format.

Arizona Department of Insurance

2910 N. 44th Street, Suite 210
Phoenix, Arizona 85018

400 W. Congress, Suite 152
Tucson, Arizona 85701

May 2003

Timely Pay Grievances

Health Care Providers Rights

Janet Napolitano, Governor
Charles R. Cohen, Director

Arizona Department Of Insurance

Life and Health Division
(602) 912-8464

Health Care Providers Rights

In 2000, the Arizona Legislature passed House Bill 2600, the Managed Care Accountability Act. The new law governs the timing of payments from health care insurers to health care providers. The new law also requires health care insurers to establish internal grievance processes for disputes between health care providers and health care insurers.

The timely pay provisions of the law apply to claims for dates of service starting January 1, 2001. The grievance procedures of the law are effective January 1, 2001.

The law does not apply to AHCCCS, Medicare fee-for-service, county health system, worker's compensation or self-insured employer claims.

This pamphlet from the Arizona Department of Insurance summarizes the timely pay and grievance law for health care providers and explains what assistance is available from the Department.

TIMELY PAY

Claims Approval or Denial

1. All health care insurers must approve or deny any clean claim:
   - Within 30 days of receipt, or
   - If there is a written contract between the provider and the insurer, within the period specified in the contract.
2. If an insurer needs additional information to approve or deny a claim, it must:
   - Make the request in writing within 30 days of receipt of the claim, and
   - Notify the provider of all the specific reasons for delay in approval or denial.
3. Insurers may not request information that does not apply to the medical condition at issue.
4. An insurer must approve or deny the claim within 30 days of receiving additional information. An insurer may not delay payment of a clean claim or pay less than the contracted amount without reasonable justification.
5. An insurer may not request providers to resubmit claims information the provider can document it already has provided unless:
   - There is reasonable justification, and
   - The purpose of the request is not to delay payment.

Payment and Interest

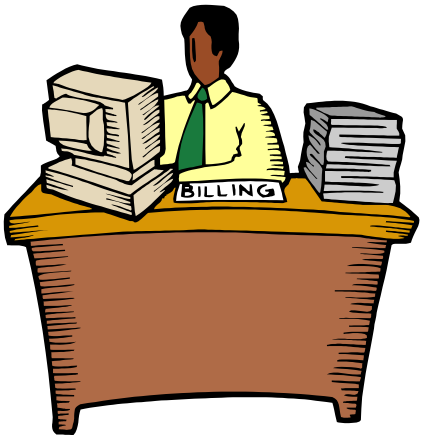
1. If an insurer approves the claim, it must pay the claim:
   - Within 30 days from the approval, or
   - If there is a written contract between the provider and the insurer, within any period specified in the contract.
2. If a claim is not paid in the required time frame, the insurer must pay interest on the amount due to the provider. Interest begins to run the last day of the required time frame.
3. An insurer must pay interest at the legal rate, which is:
   - Ten percent per annum, or
   - Any other rate agreed to in writing by the provider and the insurer.
4. The insurer's obligation to pay interest may not be waived.
5. Starting January 1, 2001, neither insurers nor providers can request adjustments of payments more than one year after the insurer pays a claim, unless there has been fraud.
6. The timely pay law has no impact on contractual provisions that are not addressed by the statute, such as time periods for the submission of claims.

GRIEVANCES

1. All health care insurers must have an internal grievance system for resolving provider disputes.
2. The Insurance Department requires each health care insurer to:
   - Describe its grievance system in a written form that is available to providers, and
   - Provide the Department with contact information for the person designated to receive grievances. To obtain this information from the Department, call the Department's Provider Information Line at (602) 912-8468

Chapter 2

DOCUMENTATION



Most insurance carriers and Health Maintenance Organizations (HMOs) outline the minimal documentation they require for payment of claims. Some insurers require physician orders (scripts) for the evaluation and continuation of treatment, for example, but do not require standardized and formal daily notes or progress note documentation. Providers must be able to produce standardized documentation regarding the services provided, and the progress obtained is more likely to receive reimbursement. By using the Insurance Coverage Verification form and calling the insurance company before services are rendered, providers know up front what is needed with their Centers for Medicare & Medicaid Services (CMS) 1500 form. Please see page 25 for an example of the Insurance Coverage Verification form.

Documentation serves the following purposes:

- It provides a record of the client's condition and the course of treatment from initiation of the Individual Service Plan (ISP) through the time of discharge.
- It serves as an information source for families.
- It facilitates communication among the professionals involved with the client.
- It provides a method for documenting quality assurance.

ELIGIBILITY AND VERIFICATION OF BENEFITS

1. Call the Benefits Verification department of the insurance carrier. The phone number can generally be found on the back of the insurance identification card. If you do not have a copy of the card, use the general phone number for the insurance company provided by the family on the referral form.

2. Identify yourself as a provider and that you want to verify benefit coverage. The insurance company representative will ask you for your provider identification number or your social security number, and upon verifying your information, will ask for the name, policy number, and date of birth for the client. The representative will ask you what type of benefits you are calling to verify (Nursing, Occupational Therapy, Physical Therapy, or Speech Therapy).

3. The representative will likely tell you that the verification of benefit is a "quote only" and not a guarantee of payment. A final determination regarding reimbursement will be made when the actual claim is sent in and reviewed by the insurance company. The representative will tell you whether or not the service is covered and what the rate of reimbursement is. For example, "This policy does have speech therapy benefits, payable at 80% of usual and customary charges, subject to a calendar year deductible of $250". That simply means that they will reimburse you for 80% of your fee, if your fee is considered reasonable for the service provided, and if the deductible for your client has already been met for the current calendar year. (More information about deductibles is provided elsewhere in this manual.)

4. If the insurance representative does not volunteer any information to you about policy limitations, be sure to ask if there are any. Here are a few examples of limitations that an insurance company might have for speech therapy benefits:

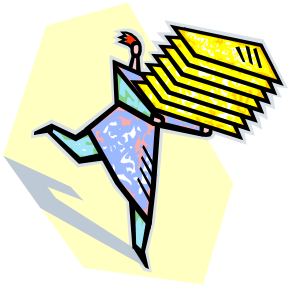
    - A pre-certification, or pre-authorization is required
    - A referral must be made by the primary care physician
    - Services must be medically necessary
    - Services must be provided by a licensed S&LP (Speech & Language Pathologist)
    - Limited number of visits per year
    - Limited number of visits per diagnosis
    - Maximum amount payable per year
    - Maximum amount payable per lifetime
    - Reimbursement is made only for a particular diagnosis or event
    - Reimbursement is made only to preferred providers for their company
    - A lower rate of reimbursement may be available for non-preferred providers of their company.
    - Benefits payable by insurance carriers generally have some type of limitations. Be sure to ask for them if they are not volunteered to you!

5. *Verify the claims billing address*. Many insurance carriers have separate claims-paying facilities, and if your claim is sent to the wrong address, it will add several weeks to the date you are reimbursed if the claim is even forwarded. Some providers choose to send their initial claim by certified mail; That way an insurance company cannot say they never received the claim.

6. Be sure to get the name of the person you spoke with, and write down the information you receive. You can write down the information you receive on the Insurance Coverage Verification Form (see page 25 for example) - the form was put together by providers for their own use. If you do not fully understand the insurance company quote, ask again, or call again.

7. If the services are not covered by the family's private insurance carrier, ask the representative to state that in writing, and send/fax you the statement for your records. You will then have evidence that the carrier should not be billed for the services, and you will be permitted to bill the Division directly, without having to bill the insurance carrier first. You must submit a copy of the statement from the insurance company to the Division with your initial claim for each type of service.

8. Initiate services, and once performed, bill the appropriate insurance company on the CMS-1500. See example of form on page 34.



If the client or client's family states his/her private health insurance has been canceled, he/she should be advised to contact his/her support coordinator to correct the Third Party Liability (TPL) record. Once the TPL record has been corrected, the provider may bill the Division directly.

9. In Summary: Never rely on what you think is true about benefits or providers covered under the plan - even if they are stated in the family's most recent benefits handbook. Always double-check whether the benefits or services are covered under the client's plan before therapy services are rendered. Per your contract with the Division, you still need to bill the insurance company, however, you'll be one step ahead by knowing the benefit. Remember to take notes. Get the representative's name and write it down, along with the date, time, and general details of your conversation. If a claim problem arises and you need to file a grievance, these notes will come in handy. Most insurer's customer-service phone calls are tape recorded. Having the date and time of your call will make locating your call history with the representative much easier. Plus, the representative will be less apt to disregard your request if you have clear and concise information about your past call.

Participation / Consent Form

The DD-393 form (or the provider's own similar form) must be signed by the policyholder or individual consenting to having the Third Party Liability billed. If neither is signed, insurance is not allowed to be billed. The form includes a statement for the authorization to release information to insurance that is necessary for processing a claim and assigns benefits to the provider. The policyholder or individual consenting can also sign the 1500 form.

Physician Script

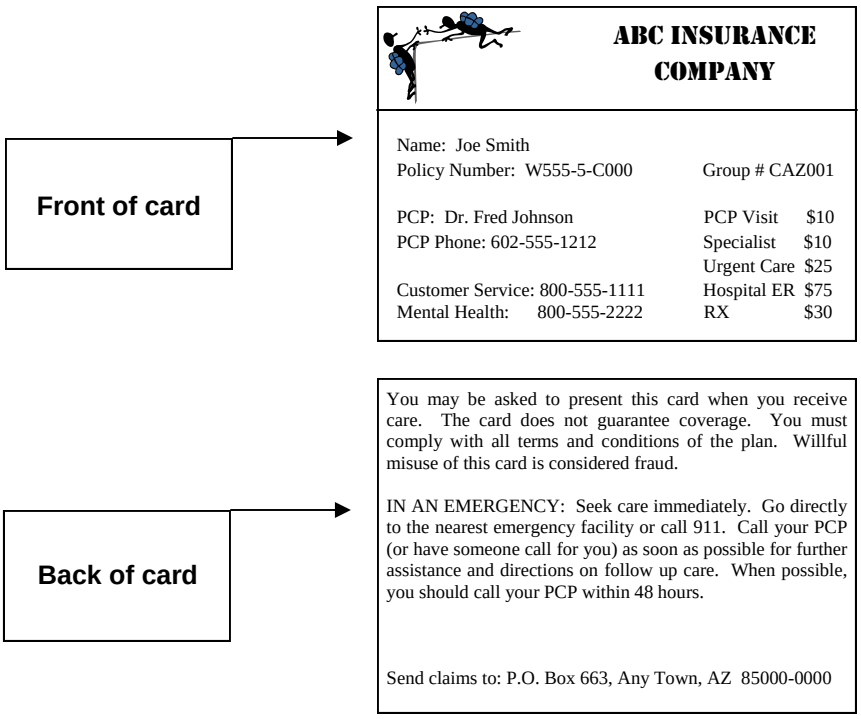
In order for a provider to bill private insurance plans, it is mandatory to have a physician's script. The script should detail if the therapy is for an initial evaluation and/or treatment, what type of therapy, frequency and duration of treatment. Before the URF or therapy referral is sent/given to the therapist, the support coordinator will already have sent the Request for Therapy Prescription letter to the primary care physician and it should be included with the therapy referral to you. The physician orders should be maintained in the treatment record.

Provider Qualifications

A provider should also keep on file documentation regarding licensing/certification of practitioners. For insurance purposes, practitioners whose services may be billed would include:

Occupational Therapist	Licensed by the Arizona Board of Occupational Therapy Examiners.
Physical Therapist	Licensed by the Arizona Physical Therapy Board of Examiners.
Speech/Language Pathologist	Licensed by the Arizona Department of Health Services.

Insurance Card example



Each insurance card is different, depending on the format the insurance company uses. Some items on the card are called different names, such as group number and account number.

The main items to look for on the card are the following:

1. Policy number
2. Group number
3. Insured
4. Claims address
5. Customer Service telephone number

Patient Name: _____

Date of birth: _____

INSURANCE COVERAGE VERIFICATION FORM

Insurance Company: _____ Rep Name: _____

Phone #: _____ Date: _____ Time: _____

Prior Authorization #: _____ Policyholder Name: _____

Claims Address: _____ Policy No.: _____

_____ Group No.: _____

_____ Employer:_____

Effective date of coverage: _____ Term Date (if applicable):_____

What type of Plan?: HMO EPO PPO Other

Network choice?: In In & Out

Coverage for: OT? ___PT? ___ST? ___

Limit to number of visits? Yes / No

Prior Authorization Required? Yes No Auth# _____

Phone#: _____ Dates Authed: _____ # of visits: _____

FAX#: _____ Contact Name:_____

Letter of Medical Necessity Required: Yes / No

Accept Electronic Claims?: Yes / No

Physicians Name: _____

Diagnosis & ICD-9 Codes:

Phone #: _____

1. _____

FAX #: _____

2. _____

Paperwork required with claims submission:

3. _____

_____

4. _____

_____

DD-213 (4-06)
P/P Ch. 600

Arizona Department of Economic Security

PRIMARY CARE PROVIDER
REQUEST FOR THERAPY PRESCRIPTION

Dear Primary Care Provider,

Your patient, referenced below, currently receives services through the Department of Economic Security's Division of Developmental Disabilities (DES/DDD). The Individual Support Plan (ISP) team has identified a need for the therapy services indicated below:

	Evaluation	Ongoing	Frequency/Duration	Special Instructions/Restrictions
Occupational Therapy	☐	☐	_____	_____
Physical Therapy	☐	☐	_____	_____
Speech Therapy	☐	☐	_____	_____

To provide ongoing services, AHCCCS requires a written order from the Primary Care Provider. This order becomes part of the individual's record and must include the patient's diagnosis (below).

Patient's Name: _____ Date of Birth: _____

Mark all diagnosis' that apply:

☐ Cerebral Palsy ☐ Autism ☐ Mental Retardation ☐ Epilepsy ☐ At Risk

Additional diagnoses: _____

If you agree the above therapy recommendations are medically necessary, please sign and fax/mail this signed letter to the name and address below:

Support Coordinator's Name: _____

Phone No.: (____) _____ FAX No.: (____) _____

Address: _____

Primary Care Provider's Name _____

Primary Care Provider's Signature: _____ Date: _____

☐ Check if signing for Primary Care Provider *(substitution permissible)*

CPT CODING

What is CPT (current procedural terminology)? CPT is a list of descriptive terms and identifying codes for reporting medical services and procedures by physicians and other healthcare providers. The purpose of CPT is to provide a standard language that describes medical, surgical, and diagnostic services, and serves as a method for nationwide communication among physicians, patients, and third party payers including Medicare, Worker's Compensation, Personal Health, and Automobile lines of insurance. CPT is used to report healthcare procedures and services under public and private health insurance programs. The American Medical Association (AMA) developed CPT in 1966. CPT was intended to encourage use of standard terms in medical records. CPT also helped to communicate accurate information on procedures and services to agencies concerned with insurance claims. Today, in addition to use in federal programs (Medicare and Medicaid, AHCCCS in Arizona), CPT is used extensively throughout the United States as the preferred system of coding and describing health care services by most private insurers.

Who maintains CPT? The American Medical Association (AMA) CPT Editorial Panel maintains CPT. This panel may revise, update, or modify the CPT codes. The Panel is comprised of 17 members. Eleven (11) are physicians nominated by the AMA. The following associations each nominate one member; the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association, the Centers for Medicare and Medicaid Services (CMS). The co-chair and a representative of the Health Care Professionals Advisory Committee (HCPAC), a specialty advisory committee, are also on the committee. CPT codes are updated annually and are effective for use on January 1 of each year. The AMA prepares each annual update so that the new CPT books are available in the fall (generally November) of each year preceding their effective date to allow for implementation. Procedure and diagnosis coding is a precise process which requires an understanding of medical terminology and clinical procedures. If the provider is not doing the insurance billing, the provider should assign third-party activities to employees or contractees who have knowledge of medical terminology. The goal should be to maximize third party funding. It is the responsibility of the client's primary care provider (PCP) to assign a diagnosis; the provider assigns the procedure code(s) for services.

The provider should select the procedure code that most accurately identifies the services performed. It is unnecessary to provide the written description on the filing form when the numeric code is provided. For procedure codes, refer to the *Physicians' Current Procedural Terminology, (CPT).* Books listing the codes may be purchased from a local technical bookstore or from Order Department: American Medical Association, 515 N. State Street, Chicago, Illinois 60610. Toll free ordering: 800-621-8335.

You can also access CPT code information on the following website: https://catalog.ama-assn.org/Catalog/home.jsp. Click on CPT Online. Under "Downloadable Coding Products/Education (CPT Online)", click on "CPT Code/Value Search".

For more information about CPT coding, go to:

http://www.ama-assn.org/ama/pub/category/3113.html

DIAGNOSTIC International Classification of Diseases 9th Revision (ICD-9) CODING

Most, if not all insurance carriers, Health Maintenance Organizations (HMOs) and other insurance companies require the use of ICD-9-CM codes in the billing format. There is adequate space for listing up to four codes on the standard billing claim form, the Centers for Medicare & Medicaid Services (CMS) 1500. The primary diagnosis, the condition considered to be the major health problem for which the particular treatment is provided, should be listed first. All diagnoses affecting the current treatment of the client should be included. If using internet sites, or other resources to obtain codes, it is the provider's responsibility to ensure that the submitted codes are valid and consistent with the ICD-9 coding manual before submitting claims to an insurance company. Using the correct and age-appropriate diagnosis impacts benefit payments. Always use the fourth and fifth digits when indicated as necessary.

There are several free websites to access ICD-9 Codes:

- ✓ http://icd9cm.chrisendres.com/index.php
- ✓ http://www.cdc.gov/ncbddd/dd/default.htm
- ✓ http://www.eicd.com/

Please keep in mind that obtaining the most current/ correct code is the provider's responsibility.

You can buy the American Medical Association's ICD-9 book through the Order Department, American Medical Association, PO Box 930876, Atlanta, GA 31193-0876. Orders can be called in to: 800 621-8335 or faxed in to: 312 464-5600.

CHAPTER 3

INSURANCE FILING FORM PREPARATION

After written permission has been obtained from the child's family, and insurance benefits have been verified, services may be rendered.

The provider or their billing company will bill the appropriate party. The Division will reimburse providers as the payer of last resort - private insurance plans are *always* billed first. Providers may bill the Division first only for families with no private insurance or in instances where insurance cannot be billed. In that instance, the provider would need to contact the Benefits Coordinator.

If the child is covered by both a private insurance plan and AHCCCS, bill the private insurance plan first, then bill the Division. You don't have to bill AHCCCS.

Establishing Rate Schedules

The provider determines a fee for each type of service (procedure) to be filed to the third party. Insurance carriers and Health Maintenance Organizations (HMOs) routinely reimburse providers on a standardized U&C (usual and customary) fee-per-procedure code, which is calculated based on the standard fees submitted by providers within the same grouping and geographical area. Some carriers fund for the fee submitted by the provider if the fee is lower than the customary fee. Providers may wish to call other local healthcare providers to obtain data regarding community standards when developing fee schedules.

Providers of healthcare routinely calculate U&C (usual and customary) charges based on the costs of providing services. Providers need to consider the following parameters when determining fees for related services:

- Equipment costs and depreciation
- Consumable supply costs
- Indirect department costs - costs associated indirectly with services, (such as typing, office supplies, billing forms, scheduling, etc.)
- Personnel costs - direct treatment time and preparation time for practitioners Administrative costs
- Profit margin

For more information about establishing your rates, check with your therapy professional association or check online for rate spreadsheet examples

The Centers for Medicare & Medicaid Services Claim Form (CMS 1500)

Treatment date and charge information flows from the provider to the third-party payer via the claim form. The standard claim form, adopted by the American Medical Association is the Uniform Health Insurance Claim Form, known as the CMS 1500, formerly the HFCA 1500. It is currently accepted by all private insurance carriers, self-funded plans, and HMOs in the United States These forms are available from a medical supplier, medical bookstore, some office supply stores, county medical society, or the American Medical Association. Information regarding cost can be obtained by contacting the AMA at (800) 621-8335. Photocopies of the CMS 1500 are acceptable by many insurance carriers; check first to verify whether they'll accept a photocopy or an original red and white form.

Providers may decide to contract with an agent who chooses to use a computer-generated format of the CMS 1500 or to complete purely "electronic claims." Electronic claims, eliminating the use of paper, provide the billing data from the place of service directly to the insurer's computer system, using a telephone modem. Regardless of which standardized format is used by the provider, it is important to note that claims are paid more frequently and in a timelier manner when standard forms are used.

CMS 1500 REQUIREMENTS

The CMS 1500 Claim Form is separated into two parts. The first part (blocks 1-1 3) contains information about the patient and the insured. The second part (blocks 14-33) contains information regarding the services provided by the provider. Please note that not all sections need to be completed.

The following procedures should be used when completing the CMS 1500 form. (See copy of CMS 1500 form on page 34.)

I. **Payor type:** Optional.

Ia. **Insured's Identification number:** Enter the insured's policy identification number, including any letters. This number is found on the insured's insurance identification card.

2. **Patient's name:** Enter the full name of the client, including complete last name, first name and middle initial.

3. **Date of birth and sex:** Enter the client's date of birth in a month, day and year format. Enter an "X" in the appropriate box either for Male or Female.

4. **Insured's name:** Enter the complete name of the insured.

5. **Patient's address:** Enter the client's complete address.

6. **Patient relationship to insured:** Enter an "X" in the appropriate box.

7. **Insured's address:** Enter the insured's complete address.

8. **Patient status:** Optional.

9. **Other insured's name:** If the client is covered by additional insurance plans, enter the name. This only happens when there are two private insurance plans for the client.

9a. **Other insured's policy or group number:** If the client is covered by additional insurance plans, enter any available policy numbers of those plans in this section.

9b. **Other insured's date of birth:** Enter other insured's date of birth in a month, date and year format.

9c. **Employer's name:** Enter the complete name of the other insured's employer.

9d. **Insurance plan name:** Enter the other insured's plan or group name

10. **Is patient's condition related to:** Not required.

11. **Insured's policy group or FECA number:** Enter the "group number or "group name" found on the insurance identification card.

11a. **Insured's date of birth and sex:** Enter the insured's date of birth in a month, day and year format. Enter an “X” in the appropriate box either for Male or Female.

11b. **Employer's name:** Enter the complete name of the insured's employer.

11c. **Insurance plan or program name:** Enter the program or group plan name.

11d. **Is there another health benefit plan:** Enter an "X" in the appropriate box. If yes, complete 9 a-d.

12. **Authorized person's signature:** It is imperative that the parent or guardian sign a release of information prior to billing the insurance carrier. The release allows the provider to share information with the insurance carrier that is necessary to process claims. "Signature on file" can then by typed into this space.

13. **Authorized person's signature:** The signature of the insured is required to allow the carrier to pay benefits directly to the provider and thus it is wise for the provider to maintain a written "assignment of benefits" on file from every family with private insurance. Carriers will generally accept "Signature on file" in this space and pay directly to the provider.

14. **Date of illness or injury:** Not required.

15. **If patient has had same or similar illness give first date:** Not required.

16. **Dates patient unable to work in current occupation:** Not required.

17. **Name of referring physician:** Not required.

17a. **ID number of referring physician:** Not required.

18. **Hospitalization dates related to current services:** Not required.

19. **OMIT**

20. **OMIT**

21. **Diagnosis or nature of illness:** Enter the ICD-9-CM number(s) related to the services provided. Up to four codes may be listed, with the primary code first—always list the most critical diagnosis first. One individual code per service may be entered.

22. **OMIT**

23. **OMIT**

24. **Date(s) and Place(s) of Service:**

Column A — Date of service: Enter month, day, and year that relate to the service or procedure provided. The "From" and "To" should always be the same.

Column B — Place of service: Enter the place of service code, using the codes listed on the back of the claim form.

Column C — Type of service: Leave blank.

Column D — Procedures, services: Enter the appropriate procedure code (CPT4).

Column E — Diagnosis code: Corresponds to #21. List as 1, 2, 3 and so forth.

Column F — Charges: Enter the charges for the procedures provided.

Column G — Days or units: Enter the number of units in relation to the dates of service and procedure code.

Columns H. 1. J, K Leave blank.

25. **Federal tax ID number:** Enter the FEIN or social security number of the provider.

26. **Patient's account number:** Enter the patient's account number if one has been established.

27. **Accept assignment:** The provider indicates by making an "X" in the appropriate box whether or not it will accept assignment. It's best to always mark an "X" in the yes box.

28. **Total charges:** Enter total of all the charges itemized in Section 24, Column F.

29. **Amount Paid:** Leave blank, unless this claim is to the secondary insurance carrier and reimbursement has been received from the primary carrier. Then enter the amount received.

30. **Balance due:** Enter the Total charges amount from Box 28, or if primary carrier reimbursement is known, enter balance due.

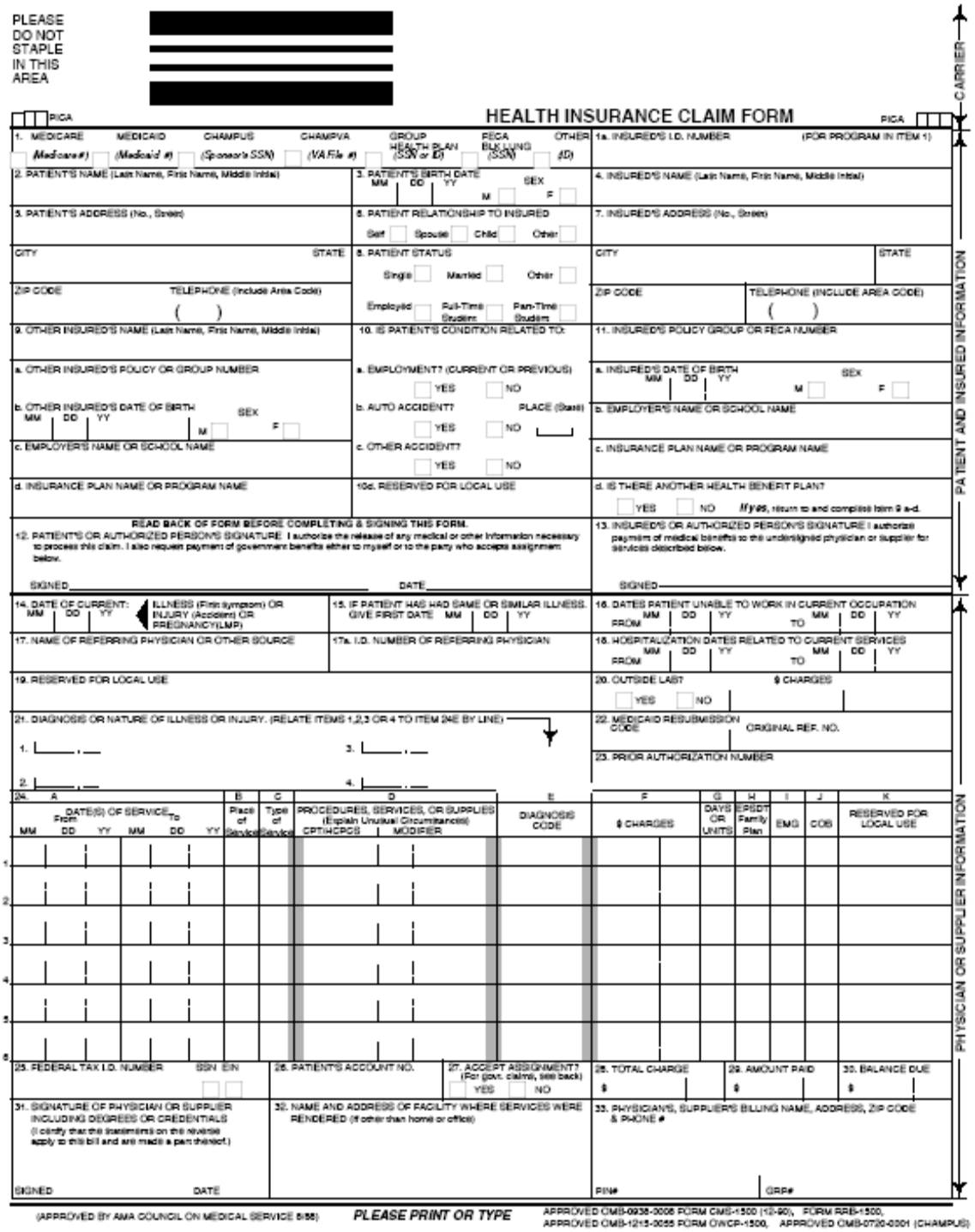
31. **Signature of provider:** The provider or authorized representative must sign the provider's name, credentials and date. Most carriers accept a signature stamp or computer-generated signature.

32. **Name and address of facility where services were rendered (if other than home or office):** Fill out accordingly.

33. **Provider's billing name, address, zip code, phone:** Enter provider name and address.

As a reminder: The Centers for Medicare & Medicaid Services (CMS) 1500 will have a format change in 2007 to accommodate the National Provider Identifier (NPI).

EXAMPLE OF CMS 1500 FORM



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1.										
2.										
3.										
4.										
5.										
6.										

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CHAPTER 4
REIMBURSEMENT PROCESS

Once the CMS 1500 is generated and checked for accuracy, it should be transmitted to the applicable claims office. Timely filing is mandatory, since third-party payers generally require filing within one year of the date of service; each insurance company has their own filing timelines - to be sure, check with them before filing your claim. A provider should develop their own directory of those companies and contact persons with which they conduct substantial activity. Under ideal circumstances, the insurance company claims office will process the claim within three to six weeks.

With an assignment of benefits, obtained as part of the parent consent/participation, the provider should be paid the appropriate insurance proceeds. Most plans will enclose an explanation of benefits (EOB) to explain the calculations involved in the process. (See samples on pages 38-39).

Follow-up with the third-party payer is required when:

1. it is necessary to respond to requests for clarification or additional information,
2. an unusually long period of time has elapsed after the claim is filed without a response, or
3. the response is inadequate.

Inquiries from Third-Party Payors may include questions regarding an incomplete or inaccurate form, or requests for additional records to document or support the information submitted.

If using a billing service, it is only through trial and error that the provider's insurance representatives can become proficient in the effective follow-up process with third-party rules, which seem to change frequently. It is helpful if the provider's third-party specialist has knowledge of insurance terminology, claims processing methods across plans, and benefit structures of private and public plans.

Note: It is important to record claims activity - if it makes it easier for you, use the Billing Progress Notes (see example in this guide) to track your claims. If you need help from the Division, all the documentation is there!

If you haven't received an Explanation of Benefits from the insurance company in 45 - 60 days from date of submittal, and you have been in contact with the insurance company, trying to obtain either a payment or denial, notify the Benefits Coordinator and request help. We want to help you to succeed!

Insurance co-pays are built into your contracted rate from the Division. Therefore, co-pays are not allowed to be recouped from the client and/or family.

REPORTING / TRACKING THIRD-PARTY / DIVISION PAYMENTS

As a control function, a provider should set up an accounting system. This can be used to evaluate satisfaction of end goals, such as effective maximization of third-party payments, and to assist in the satisfaction of means goals, such as efficient completion of insurance claim forms.

A properly implemented and maintained "related-service" financial accounting system can provide the necessary details to have on hand when checking on claims status with insurance plans.

As the Explanation of Benefits (EOB) and funding are received, the provider will want to document the activity. The EOB reports the processing of the claim and the benefits payable to denied or applied to the deductible.

WAIVER PROCESS

If the insurance company **denies** the claim, the provider (or billing representative) will do the following:

1. Check the Explanation of Benefits (EOB) for accuracy (verify the denial reason is correct) - see page 37 for examples of acceptable reasons.
2. Complete a Waiver Request Form - see page 54 for an example of a completed Waiver Request Form (you can request the forms be mailed or emailed to you by the Benefits Coordinator).
3. Submit the completed form *and* the EOB's by mail or fax to the Benefits Coordinator.
4. Providing the documentation received is correct and adequate, the Benefits Coordinator will write a waiver for the service, for the calendar year, *in most cases*. Most insurance plans benefits packages change with the calendar year, so if a therapy claim denies in February, chances are great that the claim would still deny in July or October.
5. After receiving the completed waiver form, the provider can bill the Division as the primary until the end of the calendar year. On your paper bill form, you'll write the insurance code in box 19, TPL Code. If you're still seeing the same clients in the new year that you had waivers on the previous year, you'll need to bill all insurances again. Plans change from year to year.

Acceptable Denial Explanations:

- **Not a covered benefit**
- **Benefits are exhausted.**
- **Not medically necessary**
- **Termination of policy**
- **Pre-existing condition**

The Division always pays the insurance plan's deductible, up to the provider's contracted rate.

Possible Explanation of Benefits (EOB) Explanations:

- Claim missing place of service code
- Diagnosis code does not correspond with CPT code
- Incorrect ICD-9-CM code with failure to use forth or fifth digits when required
- Duplicate claim
- Patient ineligible for dates of service
- Your claim was given individual consideration and reimbursed accordingly
- Provider number is not on file; contact Electronic Data Systems (EDS) enrollment for assistance
- Policy number missing/invalid/not on file
- Recipient name/number mismatch/ missing/invalid
- Recipient ineligible for date of service billed/unknown
- Claim denied; provider name/number on claim doesn't match our files
- Other insurance indicator missing/invalid
- Primary diagnosis missing/invalid
- Please resubmit on appropriate claim form
- Claim past timely filing limit
- Inappropriate procedure code

If you receive any of remarks listed above on the Explanation of Benefits you receive, call the insurance company for more clarification of the explanation, if needed.

What is a clean claim?

An electric or paper claim that requires no further information, adjustment or alteration by the provider of services in order to be processed or paid by the health insurer.

What missing information triggers a claim return?

- Insured's ID number
- Date of birth
- Gender
- Insured's address
- Date of service
- Procedure code invalid
- Diagnosis code invalid

Explanation of Benefits (EOB)

Every health insurer, including Health Maintenance Organizations (HMOs), is required to provide the insured or subscriber with an EOB form in response to the filing of a claim.

ALWAYS call the insurance company for clarification of a denial that is unclear!

The EOB must include at least the following:

1. Name of the provider of service.
2. Date of service.
3. Identification of the service.
4. Provider's charge.
5. The amount or percentage payable after deductibles, co-payment and any other reduction of the amount claimed.
6. An explanation of any denial, reduction, or any other reason for not providing full reimbursement for the amount claimed.
7. Telephone number or address where an insured may obtain clarification.
8. Information on how to file an appeal of a denial of benefits including the applicable timeframes to file.

PRETEND

Sample Explanation of Benefits

P.O. Box 663
Any town, AZ 85000

Date: 01/31/2006
Page: 1 of 1
Check# 00000000

For questions regarding this statement or to file an appeal, please call (800) 555-5555.

Product	Member ID #	Patient Name	Pat Rel	Patient Account	Member Name	Control Number	Date Received	Provider of Svc.
HMO	W555-5-C000	Smith, Joe	Child	0000225	Smith, Joe Sr.	0012350576	01/09/06	Speech, Inc.

Patient	Dates of Svc	Proc. No.	Units of Svc	Billed Amt	Allowed Amt	Msg Code	Ded Amt	Co-pay Amt	Co-ins Amt	Amt paid
Smith, Joe	01/02/06	92506	1	200.00	103.00	A1	0.00	10.00	0.00	82.40

Message Code explanation:

A1 - The payment represents the insured's contractual agreement - claim paid at 80% of allowable.

Provider Name
Provider's address
Anytown, AZ 85000-0000

EXAMPLE OF AN EXPLANATION OF BENEFITS

WHERE THE SERVICE WAS DENIED

H.M.O. Health group
1234 Easy Street
Any Town, AZ 85000
800-121-2121

Date:	01/10/06
TIN:	86-0000000
Enrollee:	Smith, Joe Sr.
Patient	Smith, Joe Jr.
Group #	123456
Group Name:	Atlas
Claim #	0123456789

PROVIDER EXPLANATION OF BENEFITS

Explanation of Benefits for Services provided by:
Speech, Inc.

This is NOT a bill

Date Of Svc	Svc Code	Total Charge	Not Covered	Reason Code	Disc. Amt.	Covered Amt.	Ded. Amt.	Co-pay Amt.	Balance	Paid At:	Payment Amt.
01/09/06	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
01/16/06	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
01/23/06	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
01/30/06	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.0	0%	0.00

Payment: 0.00

Service Code

92507 INELIGIBLE

Reason code: KJ - Coverage excludes charges that are not the result of an injury or illness as described on page 26 & 27, definitions and page 12., C., of your plan coverage booklet.

You have the right to appeal to the Contract Administrator if you disagree with the decision made on your claim. An Appeal must be made in writing to the Contract Administrator no later than 45 days after you receive this notice of denial. An appeal must include the reasons for your appealing the denial and all pertinent information and documentation which will enable the Contract Administrator to review your claim. The appeal must be addressed to Claims/Appeals, H.M.O. Health Group, 1234 Easy St, Any Town, AZ 85000. Please call our customer service number for more information.

AND FINALLY —

Always use the most critical diagnosis first on your claim form.

Make sure the Explanation of Benefits (EOB) matches the date, type of service, and provider of service on the bill you are sending to the Division.

Anytime the insurance company reimbursement is not equal to or greater than what you would have received from the Division, you may still bill the Division to collect the remainder up to your contracted rate.

Don't be afraid to challenge the insurance company's decision, if you feel they are not giving the claim "every consideration". Explain why the services are medically necessary; send them treatment notes detailing the child's progress as a result of your services; ask the client's family to write or call, commenting on the child's progress, etc. If you get a denial, be proactive. Put your materials together to form an appeal and send the claim back to the insurance carrier's claims department, but be sure to mark it as a "claims appeal" so they don't think it's a new claim and start the process all over again. The time and effort you spend in appealing insurance claims can pay off, especially once you learn which ones will be worth the effort!

If you have billed the insurance company and have not received an EOB within 30 – 45 days, call the insurance company and check on the status of your claim. Sending in another claim only delays you – the insurance company more often than not denies the second submitted claim as a duplicate. The Division cannot accept an EOB with a reason code/explanation of "Duplicate claim". If you're still unable to obtain a clean EOB, contact the Benefits Coordinator for help. Two suggestions:

1. See page 55 — fill out a Billing Progress Notes page is you're unable to get resolution from the insurance company and submit that page to the Benefits Coordinator for help.

2. Send the insurance company a letter requesting a claims determination (see example on page 41). If you copy the Arizona Department of Insurance on your letter, the Department will also track the progress of the determination. If patterns emerge, the Department of Insurance can go in and investigate an insurance company.

For families whose insurance company accesses a deductible, the Division always pays the deductible, up to the provider's contracted rate.

It may be easier to hire a billing agency to do your third party liability billing. Weigh the advantages and disadvantages of hiring someone. Ask for references and compare prices.

Example letter to insurance company

to request determination

Holly Johnson, Physical Therapist
4999 E. Fort Lowell Road
Any Town, AZ 85000

January 5, 2006

Reference: Member ID # 000054321-02
Ryan Selman

Pretend Healthcare
Attn: Claims/Appeals Dept.
PO Box 010101
Any Town , TX 78900-0101

Dear Claims/Appeals Department:

I am requesting a determination be made on the claim I submitted to ABC Healthcare on November 1, 2005, for dates of service 10/16, 10/23, and 10/30/05 (see attached CMS 1500).

I called your provider line on December 2, 2005, and spoke with Charlene, who stated the claim wasn't in your system. I resubmitted the claim on December 5, 2005. Today I called again to check the status and was told the claim is pended for medical review.

Per Arizona Revised Statute §20-3102, health care insurers have thirty days to approve or deny claims.

Thank you for your assistance in expediting my claim as soon as possible.

Sincerely,

Holly Johnson

Holly Johnson

cc: Arizona Department of Insurance
State of Arizona DES/DDD

GLOSSARY

Adjudicate - To determine whether a claim is to be paid or disallowed.

Adjuster - An individual, often referred to as a claims representative, who acts for an insurance company in the settlement of a medical claim.

Adjustments - Changes made to correct an error in billing, processing of a claim or as a result of retroactive rate change.

Allowed charges - That part of the reported charge that qualifies as a covered benefit, eligible for payment.

ALTCS - Arizona Long Term Care System

APIPA - Arizona Physician's Independent Practice Association

Assignment of benefits - An agreement between the insured and provider which authorizes the insurance carrier to pay benefits directly to the provider of services.

ASSISTS - Arizona Social Service Information and Statistical Tracking System

Attending physician - The physician in charge of the patient's medical care.

AzEIP - Arizona Early Intervention Program

Beneficiary - A person eligible to receive benefits under a healthcare plan.

Benefit - An amount payable by an insurance plan or Medicaid for services covered by the plan.

Birthday rule - The rule associated with the process of coordination of benefits in which when both parents have healthcare coverage, the insurer of the parent whose birthday falls first in a calendar year becomes the primary carrier.

Capitation - A method of payment for healthcare services in which the provider is paid a fixed fee for each person enrolled in an insurance plan. The monetary allowance for each enrollee is usually based on average costs adjusted for age, sex, and so forth, not on the type or number of services rendered to individual patients.

Carrier - The insurance company, HMO or PPO that writes, underwrites, and/or administers the health insurance policy, HMO or PPO Plan, also referred to as the insurer.

Claim - The written or electronically submitted request for payment of benefits for therapy services; standardized claim form used is the Centers for Medicare & Medicaid Services (CMS) 1500.

COBRA - (Consolidated Omnibus Reconciliation Act of 1985) - Federal legislation which mandates to some persons who would otherwise lose group health insurance coverage the right to continue coverage under the group plan for a limited time period. Employees who terminate employment for any reason other than gross misconduct, those whose hours are reduced, and dependents of these employees may continue the group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage for any of the following reasons: death of the employee, divorce from the employee, reaching the maximum age allowed under the policy, or employee eligibility for Medicare. Premium costs for COBRA coverage are borne entirely by the insured and may total up to 102% of the total employer/employee premium contribution under the group plan.

Coinsurance (Co-payment) - A provision of an insurance plan which stipulates the beneficiary's share of the cost of covered services, usually stated as a percentage of allowed charges.

Comprehensive medical insurance - A policy which provides both basic and major medical health insurance protection. Benefits are usually paid at a set percentage of all covered charges after satisfaction of a periodic deductible.

Congenital anomaly - A medical condition, present at birth, which is significantly different from the norm.

Consent - Voluntary agreement, based on an understanding of the nature of a particular action and the risks involved.

Coordination of benefits (COB) - When a patient is covered by more than one insurance, the plan provides for carriers to take into account benefits payable by another plan and determine primary and secondary responsibility.

Covered services - Those healthcare services provided to the patient which are stipulated by an insurance plan as eligible for benefit payments.

CRS - Children’s Rehabilitation Services

Customary charge - A dollar amount representing the lowest charge to a client, including any discount, for a specific service during a specific period of time by an individual provider.

Current Procedural Terminology (CPT-4) - Listing of medical terms and identifying codes for reporting medical services and procedures, developed by the American Medical Association.

DDD - Division of Developmental Disabilities

Deductible - Specific dollars outlined in the insurance plan that must be paid before the benefits of the plan become payable.

Deductible Carryover - Allows for covered services incurred within the last three months of the year to be carried over and counted toward the next year's deductible.

Denial - A claim for which payment is disallowed.

Dependent - Those individuals, other than the insured, who are eligible for coverage under the plan; generally, the insured's spouse and children.

DES - Department of Economic Security

Diagnosis - The identity of a condition, cause or disease.

Direct service - Professional services provided in a face-to-face contact with the child.

Direct supervision - Supervisor (licensed/certified personnel) physically present on school premises while services are being provided with the possibility of face-to-face contact with the person being supervised.

Disallow - To determine that a billed service(s) is not covered by AHCCCS and will not be paid.

Disability income insurance - A type of health insurance that provides periodic payment, in replacement of income, when an insured is disabled due to illness, injury or disease.

DOS - Date Of Service

Duplicate claim - A claim that has been submitted or paid previously.

Durable medical equipment - Equipment which (1) can withstand repeated use and (2) is used to serve a medical purpose. Example: a wheelchair

Effective Date - The date your insurance is to actually begin. You are not covered until the policy's effective date.

Electronic claim - Processing and delivery of a claim from one computer to another through a form of magnetic tape or telecommunications.

Eligible - One who is qualified for benefits.

Eligibility file - A file containing individual records for all persons who are eligible for coverage by the plan.

EOB - (Explanation of Benefits) Written statement from the third-party payer which explains details of benefit calculations.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment, a federally mandated program for eligible individuals under the age of 21.

ERISA - (Employee Retirement Income Security Act) - Congressionally enacted pension reform legislation of 1974 that includes stipulations which have evolved to provide insulation for self-funded plans, from individual state's insurance regulations.

Exclusions - Services, conditions, or products that are specifically listed in a policy as not covered.

Explanation of Benefits (EOB) - The insurance company's written explanation to a claim, showing what they paid or denied.

Fee for service - Payment by a third-party payer to providers of health services of specific amounts for service given.

Fiscal agent - An organization authorized to process claims.

Gatekeeper - Refers to the physician(s) in prepaid healthcare plans who perform initial medical exams or screen prospective care prior to referral to other specialists or allied health professionals within or outside the plan.

Healthcare Financing Administration (HCFA) - Federal governmental agency responsible for the administration of the Medicare and Medicaid programs under the auspices of the Department of Health and Human Services.

Healthcare Financing Administration Common Procedure Coding System (HCPCS) -
Includes three levels of standardized procedure codes:

- Level I codes are CPT numeric procedure codes:
- Level 2 are national, HCFA, alpha-numeric (A through V) codes for procedures not included in CPT codes; and
- Level 3 are local (state) alpha-numeric codes (W through Z) for procedures to meet local coding needs.

Health Maintenance Organization (HMO) - An alternative delivery system in which enrollees pay a fixed payment for comprehensive healthcare services emphasizing preventative and primary care.

HIPAA - A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

Indemnity Health Plan - Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, EPOs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Indirect service - Directing the teachers/aides in providing related services in the classroom as non-direct intervention with the child.

In-network - Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Insured - the person who is the primary policyholder in relation to the insurance plan.

Intermediary - Insurance carrier or data processing company which processes Medicare or Medicaid claims on behalf of the government.

International Classification of Diseases, 911 Revision, Clinical Modifications (ICD-9-CM) - Coding manual developed by the National Center for Health Statistics and others to standardize disease and procedures classification, A listing used by providers in coding diagnosis on claims.

Major medical insurance - Health insurance policy that provides for reimbursement of major illness and injury to insured, usually includes a deductible then provides for expansive benefits.

Maximums - Upper dollar limit a carrier will reimburse for a specific benefit or policy.

MCP - Mercy Care Plan

Medicaid - A government-sponsored medical assistance program that enables eligible recipients to obtain medical benefits outlined within the state Medicaid guidelines.

Medically needy - Individuals whose income and resources equal or exceed those levels for assistance established under a State or Federal plan, but are insufficient to meet their costs of health and medical services.

Medical necessity - A service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a disability or cause physical deformity or malfunction, and if there is no other equally effective course of treatment available or suitable for the recipient requesting the service.

Medical record - Data or information retained in some media form and related to the health status of and treatment rendered to a patient.

Medigap Insurance Policies - Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some of the costs that Medicare does not cover.

Non-covered services - (1) Services not medically necessary; (2) Services provided for the personal convenience of the patient; or (3) Services not covered under the healthcare plan.

Non-participating Provider (Non-Par) - A provider who has **not** both signed a contract with a carrier (HMO or PPO) nor agreed to provide services under the terms of the carrier and/or specific plan.

Out-of-Plan (Out-of-Network) - This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Over-utilization - Any usage of healthcare programs by providers and/or recipients not in conformance with both State and Federal regulations and laws (include fraud, abuse and defects in level and quality of care).

Participating provider - A medical care provider who has established a contractual relationship with a third-party payer to provide certain services to members of a plan.

Payment - Reimbursement to the provider of services for a claim incurred that is a covered benefit.

PCP - Primary Care Physician

Peer Review Organization - The utilization and quality control review unit that reviews the validity of diagnostic information: the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of services provided. Many professional associations have established quality of care and peer review organizations, standards and committees who complete the review process.

Plan of Care - Written statement that details the patient's condition, functional level, treatment goals and objectives, the physician's modifications to the plan, and plans for ongoing care, and potential for discharge from treatment.

POS - Place Of Service

Precertification - The process of providing required notice of proposed treatment to the patient's third-party payer.

Pre-existing Condition - An injury, disease, or disability that afflicted the insured prior to issuance of the insurance policy, and which frequently excludes the insured from coverage totally or for a specific period of time.

Preferred Provider Organization (PPO) - A PPO is similar to an HMO that uses the open panel plan of preferred providers. Individual healthcare practitioners become preferred providers and are paid on a negotiated fee-for-service basis by a purchaser group. The patient routinely participates in the health-care plan of a commercial carrier, which monitors utilization of service.

Primary Care Provider (PCP) - A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care.

Primary carrier - Insurance carrier or HMO/PPO which has first responsibility for payment under coordination of benefits.

Primary diagnosis - The condition considered to be the patient's major health problem for which treatment is rendered and on which the physician's claim is based.

Prior authorization - Process of obtaining permission, to provide services, from the carrier who will reimburse the service.

Procedure code - A statistically based code number used to identify medical procedures performed by a provider.

Progress note - A dated, written notation in the child's record detailing an encounter with the child and the child's' response to the encounter.

Provider - Provider is a term used for health professionals who provide health care services. The term refers to other health care professionals such as Occupational, Physical therapists, and Speech Language Pathologists.

Provider agreement - A contract between the provider and carrier that states the conditions of participation and reimbursement.

Provider number - A nine-character code assigned to each provider of AHCCCS services in Arizona for identification purposes.

Quality assurance program - Activities that measure the kind and degree of excellence of healthcare delivered. Quality of care is measured against pre-established standards. There are federal and state guidelines that relate to quality assurance programs within HMOs.

Reasonable and Customary Fees - The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Reimbursement - The amount of money remitted to a provider.

Release of Information - The patient's (or parent or guardian's) signature on a consent form that allows the release of information necessary to the settlement of the claim.

Secondary carrier - The insurance carrier that is second in responsibility within the coordination of benefits.

Short-Term Medical - Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

Stop-loss - The dollar amount of claims filed for eligible expenses at which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100%. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

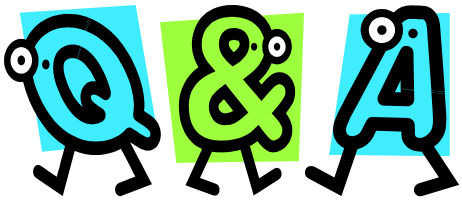
Suspended claim - "In process claim" which must be reviewed and resolved.

Third-party payer - A public or private entity that insures against risk of loss or reimburses for expenses incurred in relation to the receipt of medical care services.

UCR - (usual customary reasonable) - A third-party's method of benefit calculation which takes into account charges billed by all providers within a particular discipline and geographic region.

Unit - A session of therapeutic treatment or diagnostic assessment.

Waiting Period - A period of time when you are not covered by insurance for a particular problem.



Q. What if the child has AHCCCS only?

A. Bill the Division only.

Q. What if the client has KidsCare only?

A. Bill the Division only.

Q. What if the client has private insurance and AHCCCS? Do I have to bill both?

A. Bill the private insurance first, the Division second. You do not have to bill the AHCCCS plan.

Q. What if the client has none of the above?

A. Bill the Division only.

Q. What if the family doesn't know if the services we provide are covered by their private insurance?

A. Call the insurance company for benefits verification.

Q. What if we find out by calling the insurance company that the services aren't covered?

A. Get a written statement from the insurance company, bill the Division only, and send the denial to the Benefits Coordinator for a waiver.

Q. What if we bill the insurance company but they don't pay the claim?

A. Send or fax the Explanation of Benefits to the Benefits Coordinator for a waiver.

Q. Should we bill them the next time?

A. That depends on the reason they didn't pay it. If the services just aren't covered, don't bill them any more - only bill the Division.

Q. What if we bill the insurance company and they tell us the claim is allowable, but they don't send us any money because the deductible isn't met?

A. Bill the Division, listing the amount the insurance company paid to the deductible.

Q. Should we bill them the next time?

A. Yes! Each time you bill them, they will subtract the amount left of the deductible from what they would have paid you. As soon as the deductible equals what you've billed them, the deductible will be "satisfied", and you will receive payments from that point on.

Q. What if we bill insurance and they ask for copies of daily notes, goals, treatment plans, scripts, etc.? Can we send those things to them?

A. Definitely! Send them what they need to pay you! Be sure everything you send them is legible and professional. It is your responsibility to convince the insurance company that you are providing a necessary and valuable service to the child. Ask if you are able to fax them what is needed. Saves you time.

Q. What if the family has two insurance carriers?

A. Bill the primary carrier first. When you receive their payment and EOB, bill the secondary carrier if you have not been paid in full, up to your contracted rate amount. Be sure to attach a copy of the primary carrier's EOB to the bill for the secondary carrier. If, after billing both carriers, you still have not received payment equal to or greater than the Division rate, attach BOTH insurance carriers' EOB's and bill the Division on a Waiver Request Form.

Q. What do I do with the claims that are paid smoothly, and I receive more than the Division rate every time? Do I have to let the Division know that?

A. Yes! You will need to bill the Division for the claims you are paid on by an insurance company so that the Division knows that you provided the service, what you were paid for it, and how much money the program saved by not having to pay you because the insurance company did. This is very important information, and everyone must cooperate in providing it to the Division - it is also in keeping with your contract with the Division.

Q.What if we are not a preferred provider and there is no reimbursement available to non-preferred providers?

A. Ask how you can become a preferred provider. Generally, however, there is a lengthy process to be accepted as a preferred provider, but you may want to pursue it, especially if there are a large number of families in your area who have the same insurance carrier. Plus, you'll most likely make more than you would by billing just the Division, and pick up more private clients as well.

Q. What if they review everything and decide not to pay us?

A. You have to decide how hard and how long you want to appeal their decision. If you feel you have made your best case for payment, and can't do anymore, bill the Division and attach the Explanation of Benefits from the insurance company with the final ruling. If you feel the insurance denial is unjust, or that they have overlooked something, try again.

Q. Whose responsibility is it to notify the provider of changes to a family's insurance policy?

A. It's the provider's responsibility to notify the Division of a new policy or policy termination. Verify current coverage with the family at least quarterly.

Q. What if a provider can't get a response from an insurance company regarding their claims submission?

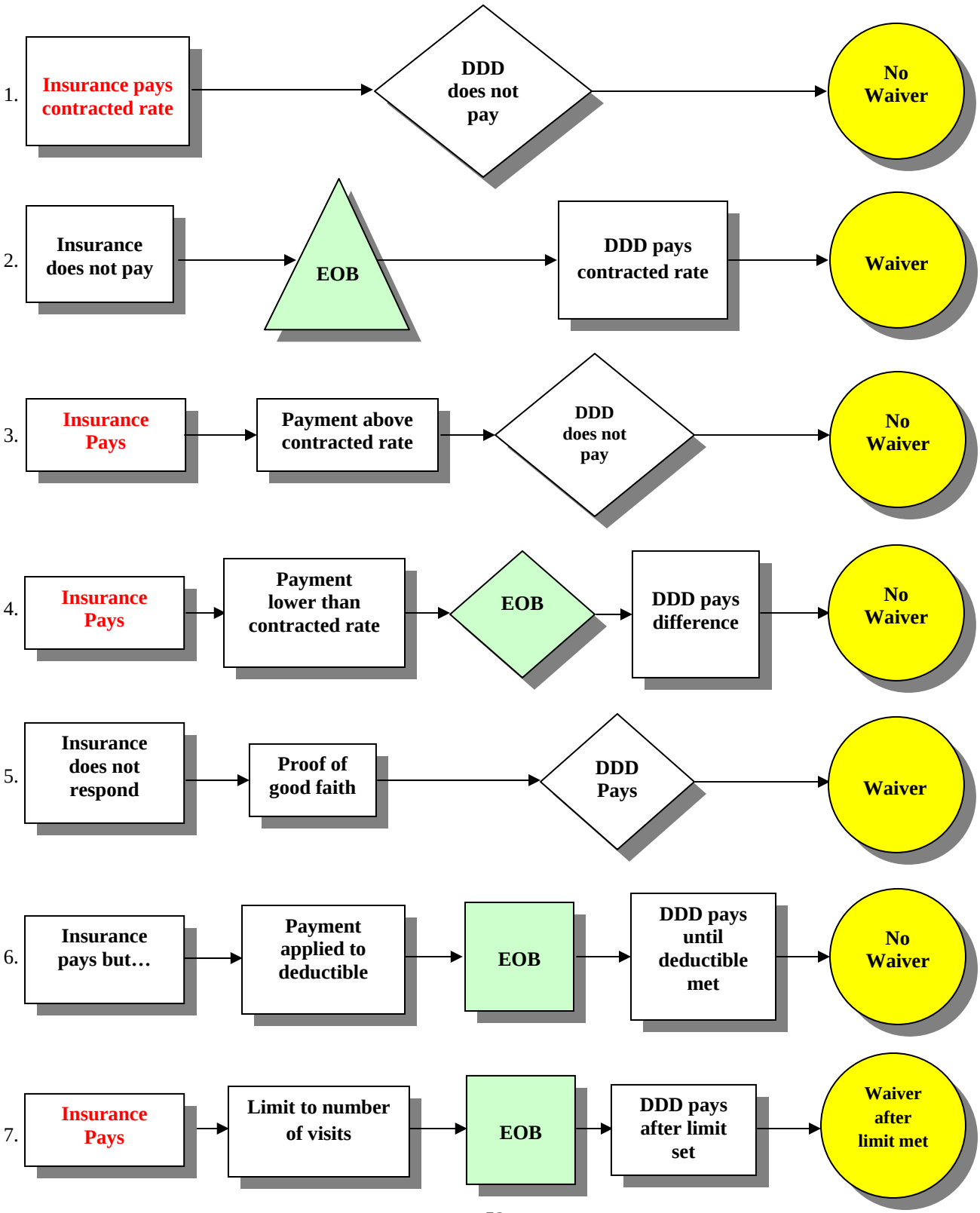
A. Per Arizona Revised Statutes, insurance companies have thirty (30) days to pay or deny a claim (see statutes at the end of this guide). If, after having exhausted all attempts at obtaining a payment or denial from the insurance company within the first 60 days after claims submittal, notify the Benefits Coordinator for help.

Q. What if I don't want to do the insurance billing myself?

A. You can always pay a billing service to bill insurance claims for you, for a fee you and the billing service agree upon.

Third Party Billing Scenarios – The Seven Steps to Third Party Billing

In all cases the Therapist must bill the insurance carrier (Third Party) before billing DDD



INSURANCE TELEPHONE LISTING

Aetna - HMO Policies	**800-624-0756**
Aetna - PPO Policies	**888-632-3862**
American Benefits	**602-264-1804**
AZ Benefits Options - Harrington	**888-999-1459**
Blue Cross Blue Shield	**800-232-2345**
BC/BS - Out of state verification	**800-676-2583**
Cigna	**800-244-6224**
Fortis (Assurance)	**800-325-8385**
HealthNet	**800-289-2818**
Humana	**800-367-7587**
PacifiCare	**800-283-7525**
PacifiCare (PPO Policies)	**866-316-9776**
Schaller-Anderson Healthcare, LLC	**866-289-6195**
Southwest Service Administration	**800-474-3485**
Tricare	**888-874-9378**
United Healthcare	**800-842-3210**

The numbers listed above are subject to change—always refer to your client's insurance card for the most current phone number.

Waiver Request Form example

Listed below is an example of how to fill out a Waiver Request Form. You can request a full-size form be emailed or sent to you by the Benefits Coordinator.

WAIVER REQUEST FORM

PROVIDER: Your name PROVIDER ID # Your provider # with the Division

ADDRESS: Your address CITY/STATE/ZIP: City, State and Zip

CONTACT PERSON: Your name or billing person PHONE # Your phone number FAX # Your fax number, if applicable

CLIENT NAME	CLIENT ID	SERVICE	INSURANCE COMPANY	INS CODE	WAIVER GRANTED YES	NO	START DATE	END DATE	DENIAL CODE
1 List client's name	Client's ID#	Type	Name of Ins.Co.	These areas are filled out by the					
2				Benefits Coordinator					
3									
4 You can list up to 15 clients									
5 per Waiver Request Form									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

REQUESTED BY: Your signature AUTHORIZED BY: Benefits Coordinator's signature

DATE: the date you sign DATE: the date Benefits Coordinator signs

DENIAL CODES:
(1) Applied to Deductible (2) Insurance change (3) No TPL (4) Other

Billing Progress Notes

Date: _____

Provider's Name: _____

Client's Name: _____

ASSISTS/FOCUS #: _____

Date billed to insurance:	Date of service:	Amount billed:

Inquiry information by phone or fax to insurance company:

Map of Arizona by District

Administration

District I office - Phoenix

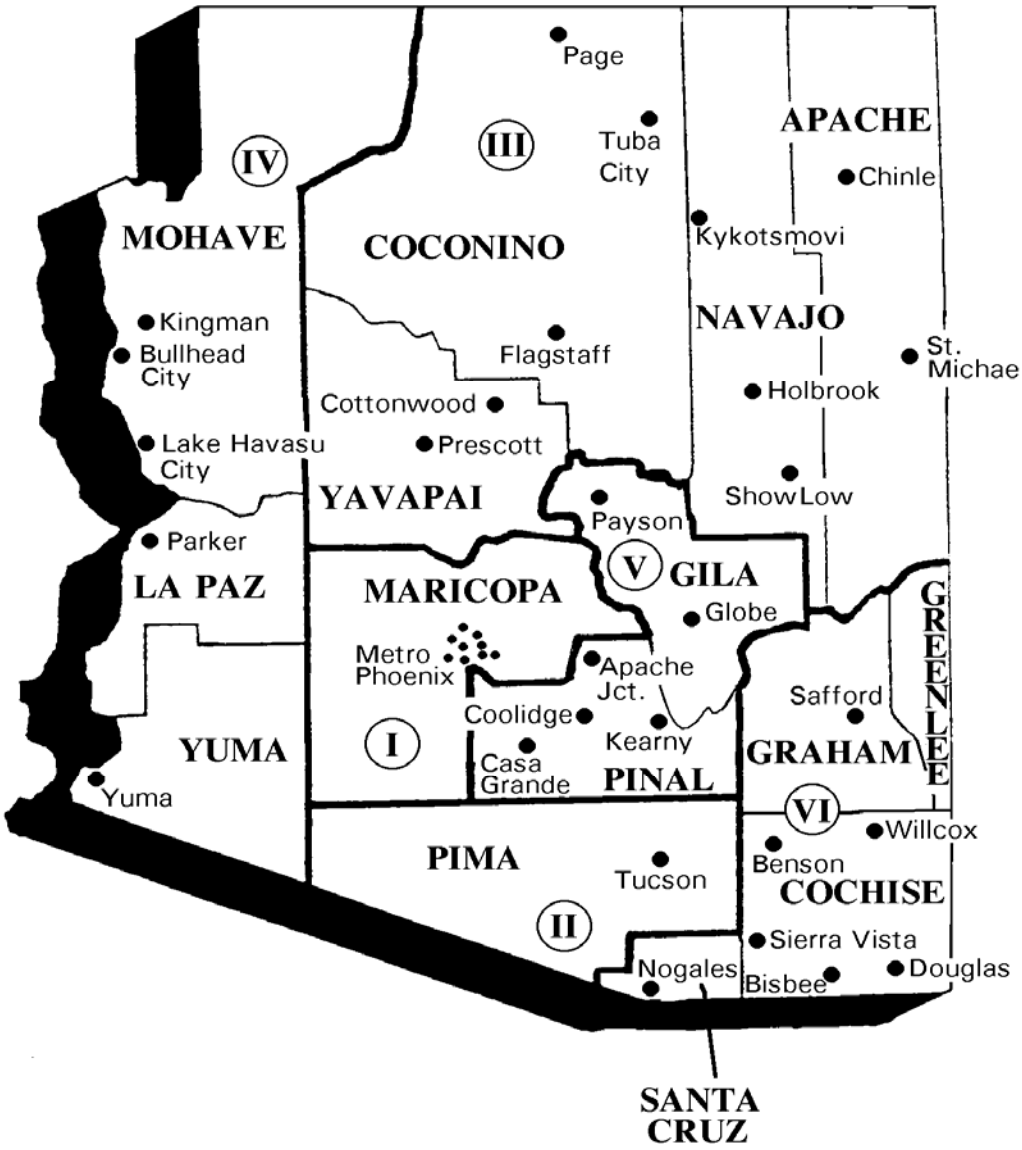
District II office - Tucson

District III office - Flagstaff

District IV office - Yuma

District V office - Apache Junction

District VI office - Bisbee



District Offices / phone numbers

Administration	1789 W. Jefferson P.O. Box 6123 Phoenix, AZ 85005	602-542-0419
District I	1990 W. Camelback Road Phoenix, AZ 85015	602-246-0546
District II	400 W. Congress, Ste 500 Tucson, AZ 85701	520-628-6800
District III	2705 N. 4th St, Ste A Flagstaff, AZ 86004	928-773-4957
District IV	350 W. 16th St, Ste 232 Yuma, AZ 85364	928-782-4343
District V	110 S. Idaho Road, Ste 240 Apache Junction, AZ 85219	480-982-0018
District VI	209 Bisbee Road Bisbee, AZ 85603	520-432-5620
Arizona Training Program at Coolidge (ATPC)	2800 N. Highway 87 P.O. Box 1467 Coolidge, AZ 85228	520-723-4151

Arizona Revised Statutes that apply to billing insurance

20-3102. Timely payment of health care providers' claims; grievances

A. A health care insurer shall adjudicate any clean claim from a contracted or noncontracted health care provider relating to health care insurance coverage within thirty days after the health care insurer receives the clean claim or within the time period specified by contract. Unless there is an express written contract between the health care insurer and the health care provider that specifies the period in which approved claims shall be paid, the health care insurer shall pay the approved portion of any clean claim within thirty days after the claim is adjudicated. If the claim is not paid within the thirty-day period or within the time period specified in the contract, the health care insurer shall pay interest on the claim at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the health care provider is due.

B. If the claim is not a clean claim and the health care insurer requires additional information to adjudicate the claim, the health care insurer shall send a written request for additional information to the contracted or noncontracted health care provider, enrollee or third party within thirty days after the health care insurer receives the claim. The health care insurer shall notify the contracted or noncontracted health care provider of all of the specific reasons for the delay in adjudicating the claim. The health care insurer shall record the date it receives the additional information and shall adjudicate the claim within thirty days after receiving all the additional information. The health care insurer shall also pay the approved portion of the adjudicated claim within the same thirty day period allowed for adjudication or within the time period specified in the provider's contract. If the health care insurer fails to pay the claim as prescribed in this subsection, the health care insurer shall pay interest on the claim in the manner prescribed in subsection A.

C. A health care insurer shall not delay the payment of clean claims to a contracted or noncontracted provider or pay less than the amount agreed to by contract to a contracted health care provider without reasonable justification.

D. A health care insurer shall not request information from a contracted or noncontracted health care provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.

E. A health care insurer shall not request a contracted or noncontracted health care provider to resubmit claim information that the contracted or noncontracted health care provider can document it has already provided to the health care insurer unless the health care insurer provides a reasonable justification for the request and the purpose of the request is not to delay the payment of the claim.

20-3102. Timely payment of health care providers' claims; grievances, con't

F. A health care insurer shall establish an internal system for resolving payment disputes and other contractual grievances with health care providers. The director may review the health care insurer's internal system for resolving payment disputes and other contractual grievances with health care providers. Each health care insurer shall maintain records of health care provider grievances. Semiannually each health care insurer shall provide the director with a summary of all records of health care provider grievances received during the prior six months. The records shall include at least the following information:

1. The name and any identification number of the health care provider who filed a grievance.
2. The type of grievance.
3. The date the insurer received the grievance.
4. The date the grievance was resolved.

G. On review of the records, if the director finds a significant number of grievances that have not been resolved, the director may examine the health care insurer.

H. This section does not require or authorize the director to adjudicate the individual contracts or claims between health care insurers and health care providers.

I. Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim. If the health care insurer and health care provider agree through contract on a length of time to adjust or request adjustment of the payment of a claim, the health care insurer and health care provider must have the same length of time to adjust or request adjustment of the payment of the claim. If a claim is adjusted, neither the health care insurer nor the health care provider shall owe interest on the overpayment or underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty days of the date of the claim adjustment.

J. This chapter does not apply to licensed health care providers who are salaried employees of a health care insurer.

K. If a contracted or noncontracted health care provider files a claim or grievance with a health care insurer that has changed the location where providers were instructed to file claims or grievances, the health care insurer shall, for ninety days following the change:

1. Consider a claim or grievance delivered to the original location properly received.
2. Following receipt of a claim or grievance at the original location, promptly notify the health care provider of the change of address through mailed written notice or some other written communication.

20-462. Timely payment of claims

A. From and after July 15, 1986 any first party claim not paid within thirty days after the receipt of an acceptable proof of loss by the insurer which contains all information necessary for claim adjudication shall be required to pay interest at the legal rate from the date the claim is received by the insurer. The interest shall be calculated on the amount the insurer is legally obligated to pay according to the terms of the insurance contract under which the claim is being submitted.

B. For purposes of determining whether the claim has been paid within thirty days, the date of payment shall be deemed to have been received by the addressee on the date shown by the postmark or other official mark of the United States mail stamped on the payment envelope. If the receipt disputes the date where there is no mark or the mark is not legible, the sender may establish the mailing or transfer date by competent evidence.

C. This section shall not apply to:

1) Claims submitted for payment under Medicare, title XVIII of the social security act (42 United States Code section 1301).

2) Claims submitted under a Medicare supplement contract where, according to the terms of the supplement contract, claims will be based upon the amount paid by Medicare.

3) The payment of a claim shall not be overdue during any period in which the insurer is unable to pay such claim because there is no recipient who is legally able to give a valid release for such payment, or in which the insurer is unable to determine who is entitled to receive such payment, if the insurer has promptly notified the claimant of such inability and has offered in good faith to promptly pay said claim upon determination of who is entitled to receive such payment.

4) Claims submitted to a person who is the processing agent for a foreign insurer or other person providing an insurance program for retirees residing in Arizona.

5) Claims denied in good faith within thirty days after receipt of acceptable proofs of loss.

D. This section shall apply only to claims that are to be paid by the insurer directly to the insured, to a beneficiary named in the contract, or to a provider who has been assigned the right to receive benefits under the contract by the insured.

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NOTES